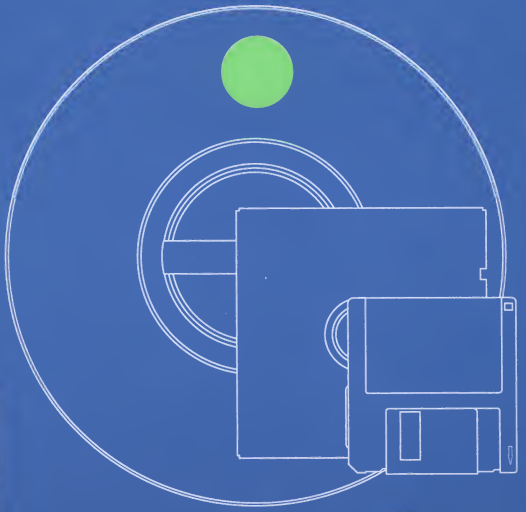
Medicare Statistical Files Manual



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U.S. Department of Health and Human Services
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Bureau of Data Management and Strategy

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MEDICARE/MEDICAID STATISTICAL FILES MANUAL

This manual has been prepared by the Office of Statistics and Data Management (OSDM), Bureau of Data Management and Strategy (BDMS), Health Care Financing Administration (HCFA). The purpose of the manual is to provide information about Medicare/Medicaid Decision Support System (MMDSS) data sets available within HCFA. It is intended to provide sufficient detail about each data set so that persons interested in HCFA programs can determine what data are available. It is not designed for use by computer personnel to write programs or perform detailed systems design.

Most files are annual files, subject to limitations such as timeliness, changes in coding structure, volume, sample size, availability of information, legislative and other changes. The reader should be aware that not all files for a given reference period may be available for processing or resources may not be available to process them. This March 1990 issuance contains either revisions or additions to the July 1988 issuance.

A Public Use File (PUF) version of many of these files is offered for sale as indicated in the table of contents.

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Further information on the MMDSS data can be obtained by contacting the Division of Data Documentation and Release, OSDM, BDMS, HCFA, Room 3-A-12 Security Office Park Building, 6325 Security Blvd., Baltimore Maryland 21207 by mail or by telephone at the following numbers: FTS 987-5151 or (301) 597-5151.

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I. Medicare/Medicaid Decision Support System

Introduction

This Publication describes components of HCFA's data collection system. Although it includes a chapter describing the Medicaid Statistical System (MSIS), most of the information collected provides the basis of the system designed to measure the effectiveness of the Medicare program. This system, by manipulating, summarizing, and combining different types of records, produces a wide variety of files and data for use by actuaries, policy analysts, researchers, and management.

Knowledge of the benefits available under Medicare and of the way in which Medicare is administered will contribute to an understanding of the Medicare Decision Support program. Medicare and Medicaid are administered by the Health Care Financing Administration (HCFA), an agency which was formed in March 1977. Before that time, the Social Security Administration (SSA) administered the Medicare program. Many of HCFA's centralized computer operations are still performed by SSA for HCFA.

Basic Provisions of Law

In 1965, amendments to the Social Security Act (Title XVIII) established two complementary health insurance programs for the aged--a hospital insurance (HI) plan (Part A) and a supplementary medical insurance (SMI) plan (Part B). The Part A plan provides coverage for hospitalization, stays in skilled nursing facilities, and home health services. The Part B plan provides coverage for physicians' services, outpatient hospital services, home health services, and other medical services.

Medicare benefit payments under both plans began July 1, 1966, except for skilled nursing facilities which began January 1, 1967. These benefits were originally available only to persons aged 65 and over. The 1972 amendments to the Act established coverage for disabled persons under age 65 and for persons with End Stage Renal Disease (ESRD). Their benefits began July 1, 1973.

Except for a short period while the Medicare Catastrophic Coverage Act of 1988 was in effect (January 1989 through December 1989), the payment of inpatient hospital benefits has been geared to a benefit period ("spell of illness"). A benefit period begins with the first day (not included in a previous benefit period) the individual is furnished inpatient hospital services and ends after 60 consecutive days during which the beneficiary is neither a hospital inpatient nor a skilled nursing facility inpatient.

There is no limit to the number of covered benefit periods the individual may have as long as entitlement to health insurance continues.

The hospital insurance plan (Part A) provides renewable inpatient hospital coverage of up to 90 days for each benefit period. After meeting an inpatient deductible, beneficiaries are entitled to up to 60 days of full coverage and 30 days of coinsured coverage for each benefit period. Each beneficiary also has a lifetime reserve of 60 additional days of hospital care

beyond the 90 renewable days allowed for each benefit period. The beneficiary also must pay a coinsurance amount for each of the lifetime reserve days used.

Each beneficiary is provided up to 100 days of care in a certified skilled nursing facility (SNF) for each benefit period but only after a hospital stay of 3 days or more. The hospital insurance plan covers the costs of the first 20 days of care, and the beneficiary pays a daily coinsurance rate for the remaining 80 days. These benefits started in 1967.

Prior to July 1981, up to 100 home health care visits annually, after discharge from a hospital or skilled nursing facility stay of at least 3 days, were covered under Part A. Effective July 1981, home health coverage under Part A of Medicare provides for unlimited visits, and the 3-day prior stay requirement was eliminated.

The SMI plan (Part B) covers such items as: physician services, diagnostic X-ray and laboratory tests, radium therapy, ambulance services, surgical dressings, other medical needs, and prior to July 1981 up to 100 home health care visits each year. Effective July 1981, unlimited home health visits are permitted but are considered Part B services only if the beneficiary does not have Part A coverage.

Generally, after a beneficiary pays an annual deductible, medical insurance will pay 80 percent of the reasonable charges for covered services for that year. For some services, however, Medicare will pay 100 percent of covered reasonable charges; e.g. services performed in an independent laboratory that are billed on an assignment basis are reimbursed at 100 percent of a negotiated rate not subject to any deductible or coinsurance.

Prospective Payment

Effective October 1, 1983, Medicare implemented a prospective payment system for reimbursing inpatient hospital operating costs. This system replaced the existing retrospective cost reimbursement system whereby interim rates were paid on each bill and end of year adjustments were made based on information contained in hospital cost reports. Hospitals are now paid a fixed amount, determined in advance, for the operating costs of each case according to one of 475 Diagnosis Related Groups (DRGs). A discharge is assigned to a DRG based on diagnosis, surgery, patient age, discharge destination, and sex. Each DRG has a weight established for it based primarily on Medicare billing and cost data. Each weight reflects the relative cost, across all hospitals, of treating cases classified in that DRG.

Additional payments are made for hospital discharges meeting specified criteria as "outliers", for pass through costs, and for disproportionate share hospital costs. Outliers are cases that have an extremely long length of stay or unusually high costs when compared to most discharges classified in the same DRG. Pass through cost payments are made for direct costs of medical education, capital, bad debts, and kidney acquisition costs. Additional payments are also made to compensate for indirect costs of medical education. Disproportionate share hospitals are those having a low income patient load exceeding a threshold amount based on bedsize and urban or rural location.

Prospective payment applies to all Medicare-participating hospitals except psychiatric, long term, childrens, and cancer treatment hospitals. Also excluded are distinct part rehabilitation, psychiatric, and skilled nursing care, units of acute care hospitals. Four States received waiver because they had, in place, all payer prospective payment systems. They were Maryland, Massachusetts, New Jersey, and New York. Effective with each hospital's 1986 fiscal year, hospitals in Massachusettes and New York are paid under PPS. New Jersey entered the prospective payment system in 1988. Maryland has retained its waiver.

Fiscal Intermediaries

Under the HI program, Fiscal Intermediaries (FI's) are selected by each institutional provider (hospitals, skilled nursing facilities, home health agencies) to act as the link between the provider and the Health Care Financing Administration. A vital role of the intermediaries is to review and pay claims for the cost of providing care to the beneficiaries. The intermediary makes these payments to providers for covered items and services and assists in the application of safeguards against unnecessary use of covered services.

For institutional providers not on prospective payment, the reimbursement amount shown on the billing records is an interim payment based on estimates of actual costs. Each institution is required to prepare a cost report at the end of its fiscal year and final payment is made on the basis of this report. These cost reports are professionally reviewed and audited as necessary by the FI. Portions of the cost reports are transmitted to HCFA to be used in rate setting and policy development.

For hospitals on prospective payment, the diagnostic, surgical, and other pertinent information shown on the billing forms are edited and then processed through a computer program called GROUPER to assign the DRG. If there are problems with the codes, the FI resolves them with the hospital. Once the DRG is assigned, the bill is processed through other operations to determine the price Medicare will pay. Hospitals on prospective payment are also required to file cost reports since a portion of the payments is based on cost data.

Carriers

Under the SMI program, carriers are selected by the Secretary of Health and Human Services. The principal functions of these carriers are to determine the reasonable charges in their respective areas for each medical care service paid for under the program and to review and pay claims to or on behalf of beneficiaries for the services provided. They also maintain customary and prevailing charge profiles of physicians in their geographic area.

Social Security Administration

The Social Security Administration (SSA) maintains demographic and entitlement information on all OASI, Disabled, and ESRD beneficiaries. These data are provided to HCFA to update the Health Insurance Master (HIM) file daily for current maintenance and utilization information. Maintenance data consist of beneficiary enrollments and

terminations, cross-reference of claim numbers, changes of address, and other changes which are received from the SSA and the Railroad Retirement Board master beneficiary record (MBR) systems. Utilization data consist of: notices of hospital admissions, SNF admissions, Part B deductible queries, provider billing records from intermediaries, and payment records from carriers. Both the utilization and maintenance data are matched to the HIM for updating as part of HCFA's administrative processes.

Hospital Insurance Claims Process

The HCFA Central Office HI Claims process operation is essential to provide current benefit and utilization information to intermediaries. It also monitors intermediary payment to institutional providers. When a beneficiary is discharged, the participating provider submits a bill to the intermediary. The intermediary then transmits the information as a query to HCFA to check the beneficiary's status and validate entitlement, deductible, and coinsurance information on the bill. Based on the information furnished by HCFA, the intermediary certifies payment to the provider. The intermediary then forwards the bill record to HCFA for processing through HCFA's administrative operations. This billing record is also sent to the local Peer Review Organization (PRO) for quality review.

Consistency Editing

This operation (performed centrally in HCFA) balances the number of bills and reimbursement amounts to the intermediary's total to establish acceptable tape totals for use through the remainder of the automated processing. A computer edit program identifies all invalid data and inconsistencies for each bill. Invalid data include such items as a month indicated by a number greater than 12, more than 60 lifetime reserve days used, and so forth. The DRG on prospective payment hospital bills is also edited.

The consistency edits do not compare data on the bills to information in HCFA records. These edits are used as a screen to check the consistency of data on the bill itself.

Utilization Editing

Once the consistency edits have been applied, the bills are processed through the utilization editing program. In this program, the bill data on the tape are compared to the data in HCFA's Health Insurance Master Record.

The bills in the batch which failed the consistency edits are screened in the utilization program for only three items:

1. name and claim number which match the master record,
2. eligibility to Part A or Part B benefits during the billing period, and
3. a matching open item on HCFA's Health Insurance Master Record. "Open" items are created from admission notices and are "Closed" by discharge discharge bills or deletion queries.

Bills which have passed the consistency edits are processed completely through the utilization editing program and are either posted or rejected. The detailed edits resulting in a potential 300 distinct error conditions are described in Section 3830 of the Part A Intermediary Manual. This manual is maintained by the Bureau of Program Operations, HCFA.

Rejected bills are returned to intermediaries for correction and reinstatement (or voiding). Both bills and batches are held in the control system until their processing is completed or until they are deleted. Reports of batch processing, batch completion, and outstanding returned bills are periodically sent to intermediaries to use in reconciling batches submitted and in checking on bills to be corrected and returned to HCFA. Records of the bills passing initial edits are passed on to the Beneficiary Master Update operation; which records the transactions on the individual's HI Master record, and generates records for updating the provider Master File; and to a history record of completed billing transactions. The update operation will also generate a beneficiary utilization notice when an interim or a final (discharge) bill is processed for inpatient services or home health visits.

Part A inpatient bill information is processed on an "in sequence" basis. This sequence is determined from the billing dates "from" and "to" present on each bill. Bills are processed in "from" date sequence within a benefit period.

Medical Insurance Claims Process

Part B outpatient bills and Part B home health agency bills are submitted from intermediaries, while Payment Records covering physician, supplier, and ambulatory surgical center services are submitted from carriers. The processing procedure differs from that for Part A bill records because, unlike Part A, Part B benefits are not tied to a benefit period with a limited number of days of care and varying coinsurance amounts. Under Part B, only physical therapy and psychiatric services have an annual limitation on benefits payable.

Claims for payment of Part B benefits are submitted to the carrier or intermediary by beneficiaries or the supplier of services (such as physicians). When the carrier or intermediary queries HCFA on the beneficiary's deductible status, the utilization query/reply operation handles the transaction similarly to Part A queries.

In addition, Part B queries update the Part B deductible and record physical therapy and psychiatric expenses. The carrier or intermediary determines and makes payment to the claimant, taking into account the beneficiary's deductible status.

Carriers submit Payment Records for all physician and supplier claims for which payment is made. These Payment Records are batched and transmitted to HCFA where they are edited and then matched against the HI Master Record to check for beneficiary entitlement and, if appropriate, to record physical therapy or psychiatric services. A listing of rejected records is returned to carriers for corrections and the records are held in a suspended record file. As records are corrected and returned, they are deleted from this file. In addition, another operation controls the batches of Payment Records and provides statistical reports on bill processing by each carrier.

The Explanation of Medicare Benefits (EOMB) is an important function of the carriers and is used to notify each claimant for Part B benefits of the action taken on his claim. Section 7000 of the Medicare Carrier's Manual provides an in-depth description of the purpose and contents of the EOMB. This manual is maintained by the Bureau of Program Operations, HCFA.

Carriers send HCFA monthly reports of amounts paid during the month for SMI services. Batches of Payment Records are matched against these carrier financial reports to determine if submitted records of payments by carriers balance HCFA's reimbursement to them for Part B payment made. HCFA then reconciles any differences.

HCFA does not receive bills for Part B services rendered by certain Group Practice Prepayment Plans (GPPP's) and Health Maintenance Organizations (HMO's). These groups deal directly with HCFA and are reimbursed on a per capita cost basis.

Provider Of Service Master File

Institutional providers of services (e.g. hospitals, SNF's, and HHA's) participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing care for the beneficiaries of the two programs. The certification is done by State agencies according to HCFA guidelines and regulations. The qualifications are reviewed periodically, following the same procedure.

The State agency surveyor applies various criteria to measure an institution's capability of providing acceptable care. At the same time, provider characteristics such as staffing, number of beds, and services provided are recorded on a forms package. This forms package is divided into two sets. The first set, called the Survey Report Form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the institution being evaluated. For example, the surveyor evaluates such areas as staffing, physical environment, medical records, nursing, and dietary departments in hospitals and nursing homes. The second set comprises the source documents for the Provider of Service (POS) master file, and includes the Certification and Transmittal Form (C&T) and the application form. The C&T Form records address information, intermediary tie-in, and the certification decisions and certification approval dates of the State agency and the HCFA regional office. The application form contains the provider characteristics (type, control, staff, services, etc.).

When the on-site survey by the State agency surveyor has been completed, it is reviewed and approved by the State agency and entered into the data base. The data items that are prescribed for entry into the data base are then keyed to magnetic disk. The first group of consistency checks are applied as the data are entered. Incorrect entries result in an alert to the operator via a Cathode Ray Tube (CRT) display screen and for certain fields prevent further entry of the forms package in question until corrections are made. Those forms packages successfully keyed to the disk are batched daily in the state agency and transmitted via telephone lines to central office. A transaction record is built in central office by combining all the POS and SRF data elements into a single record for each provider of service. This record is next passed through a more extensive series of

consistency checks for accuracy and completeness. The fully edited record is then entered into the provider of service master file. The regional office reviews the automated package and decides if the facility is certified.

The Medicare/Medicaid Decision Support System

The primary objective of the Medicare Statistical System (MSS) is to provide data required to measure and evaluate the operation and effectiveness of the Medicare program and to provide data for pre-decision support. The entitlement and benefit payment operations furnish extensive, systematic, and continuous information about the amount and kind of hospital and medical care services used by Medicare beneficiaries. The claim number that is assigned to each beneficiary serves as the link between the various services used under the program and the demographic characteristics of each individual recorded in the enrollment files. The applications submitted by hospitals, skilled nursing facilities, and home health agencies to participate in the Medicare program provide data on the characteristics of such providers of services.

The data-collection system has two inherent characteristics that primarily determine the scope, detail, and flexibility of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic unit. Second, records for each bill paid are maintained on a centralized basis. Except for intermediary operating statistics such as those relating to workloads, time lags, and costs, all program statistics are centrally prepared.

The statistical system is based on six basic record groups which are byproducts of the Health Insurance Administrative operations. The record groups are described below.

- The Health Insurance Master Enrollment Record - This record identifies each person (aged and disabled) enrolled for Medicare. Data describing the characteristics of the Medicare enrolled population are obtained from this file.

  This file also serves as the basis for obtaining Medicare utilization rates. Approximately 30 million aged beneficiaries and 3 million disabled beneficiaries are currently entitled to Medicare benefits.

- The Provider of Service Record - This file contains information on every hospital, skilled nursing facility, home health agency, independent laboratory, and other institutional provider which must apply for participation in the program. Each is assigned a distinct provider number. Approximately 6,700 hospitals, 10,300 SNFs, 5,700 HHAs, 4,800 independent laboratories, and 5,000 other facilities that participate in Medicare are on this file.

- The Utilization Record - Part A and Part B billing information is maintained centrally; these records are tabulated monthly, quarterly, and annually to measure the use of Medicare services. While the annual volume of Medicare

bills processed will vary from year to year, the approximate number processed in any year is as follows:

Inpatient hospital	10,500,000
SNF	750,000
Outpatient	49,500,000
HHA (A and B)	4,600,000
Payment Records (physicians and suppliers)	360,000,000

- The Provider Cost Report Record - This record includes accounting and financial data by provider fiscal periods which are used for rate setting and policy development. Cost data are captured on institutional providers; i.e., hospitals, SNFs, HHAs, and ESRD facilities.

- The Special Program Data - Data are collected specific to special programs within Medicare; e.g., ESRD and, as necessary, for the purpose of research, demonstrations, and policy analyses; e.g., SSI days for disproportionate share hospitals.

- The Part B Medicare Annual Data Files (BMAD) - These are supplemental Part B data files developed from carrier supplied claims history records. The files and approximate number of records contained in each are as follows:

Procedure File	8,000,000
Prevailing Charge File	20,000,000
Provider File	42,000,000
Beneficiary File	23,000,000

Since each utilization record contains both the beneficiary's claim number and the provider's Medicare identification number, these records can be matched to the Enrollment and Provider records to enhance statistical capabilities.

The billing information reported includes days of care, detailed ancillary charges, Medicare reimbursement amounts, discharge status, diagnostic and surgical information. By mid-1985, all institutional providers were reporting on the HCFA 1450 (uniform bill) billing form.

Prior to October 1983, the diagnostic and surgical information was reported in narrative form (up to 45 characters for diagnosis and 41 characters for surgery) for samples of bills only. Only one diagnosis and surgical procedure (if any) was coded. The coding system in use since 1979 is ICD-9-CM Volumes I and II for diagnosis and ICD-9-CM, Volume III, for surgical procedures. For services before 1971, ICDA-7 was used; for services from 1971 - 1978, ICDA-8 was used.

Since October 1983, hospitals are required to report only ICD-9-CM codes for inpatient hospital bills. Narratives are no longer permitted. Inpatient hospital bills must contain codes for the principal diagnosis and up to four additional diagnoses and principal surgical

procedure and up to two additional surgical procedures, if any. These data are for assignment of a Diagnosis Related Group (DRG) number to determine the amount for prospective payment. The DRG is assigned by the fiscal intermediary by processing the billing information through a computer program called GROUPER.

Medicare bills other than inpatient hospital, outpatient, home health, and skilled nursing facility were still reporting either narratives or codes until April 1985 when only ICD-9- CM codes were permitted.

Effective July 1986, providers were required to report clinical laboratory procedures using HCPCS codes. HCFA developed HCPCS by using CPT-4 for physician services and adding HCFA developed codes for certain nonphysician services. All of CPT-4 is contained within HCPCS. In July 1987, providers were required to report significant outpatient surgical procedures using HCPCS.

Major Medicare Statistical Files by Data Category

Most Medicare statistical files are summarized on a calendar or fiscal year basis by the year the service was incurred. The files contain varying amounts of detail on charges, days of care, Medicare payment, beneficiary and provider characteristics. In addition to the files, an ongoing series of detailed tabulations are prepared containing data on enrollment, bills, charges, days of care, and payments by type of Medicare benefit Nationally, by State, and by county of residence.

A. Utilization - Institutional Providers

1. Medicare Provider Analysis and Review (MEDPAR)

   This file of hospital discharges contains detailed accommodation and departmental charge data, days of care, diagnostic/surgical information, and beneficiary demographics. The file size was increased to 100 percent on October 1, 1983. Previously, MEDPAR contained data for a 20 percent sample of beneficiaries.

2. Provider Summary Record - 100 Percent

   This file contains current and prior-year summary utilization information by Medicare certified hospital, including number of bills, days of care, charges, and reimbursement. This file is primarily used for Admission Pattern monitoring and Prospective Payment System monitoring.

3. Annual Home Health Agency Bill File - 40 Percent Sample

   This file contains HHA billing data and beneficiary characteristics.

4. Annual Outpatient Bill File - 5 Percent Sample

   This file contains outpatient billing information and beneficiary characteristics.

5. Skilled Nursing Facility Stay Record File - 100 Percent

This file contains admissions with billing information, admitting diagnosis, and beneficiary characteristics.

B. Part B Data - Physicians Ambulatory Surgical Centers and Suppliers

Part B Medicare Annual Data Files (BMAD)

The Part B data are provided in four separate files; carriers extract the data annually from their claims processing history files.

1. Procedure File - Provides an array of every procedure processed showing the related frequency, submitted charge, and paid amount. This gives HCFA detail on the services processed by carriers.

2. Prevailing Charge File - Provides HCFA with the prevailing charge limits for each service contained in the Procedure File. This allows HCFA to study and accurately project payment levels. It is currently being used to establish clinical lab fee payment schedules.

3. Provider File - Contains line-by-line detail from claims history of procedures rendered by a 1 percent sample of physician/suppliers. This allows HCFA to study the impact of actual and projected physician/supplier program changes. It also allows HCFA to conduct longitudinal analysis of practice trends. The sample increased to 5 percent for 1985.

4. Beneficiary File - Contains line-by-line detail from claims history of services received for a 5 percent sample of aged and disabled beneficiaries and all ESRD beneficiaries. The beneficiary health insurance claim number enables a beneficiary's Part B service utilization data to be linked with the Part A service utilization data that exist in other central office files.

C. Longitudinal Utilization and Beneficiary Data

1. Continuous Medicare History Sample - 5 Percent Sample

A summary file which links data covering all Medicare benefits on a 5 percent sample of beneficiaries on a continuous annual basis. Beneficiary characteristics and data on each hospital and SNF stay along with diagnostic and surgical information are included. The file is often used as a longitudinal statistical data base to study beneficiary utilization of all Medicare benefits.

2. Medicare Automated Data Retrieval System (MADRS)

MADRS was designed to reorganize the massive 100 percent Bill and Payment Record Files and to index them to make it easier and less expensive to retrieve data for research and demonstration purposes.
MADRS contains extracts from 100 percent of hospital bills, outpatient bills, skilled nursing facility bills, home health bills, and physician and supplier payment records. For office visits, only summarized payment record data are available. The more important data elements available in the data set are health insurance claim number, provider number, reason for entitlement, dates of service, types of services, diagnosis, charges, payment amounts, and coinsurance and deductibles.

MADRS is accessible by either health insurance claim number or state and county of residence.

D. Financial Data

1. Health Care Provider Cost Report Information System (HCRIS)

HCRIS is an automated data collection, processing, and report generation system that contains hospital-specific financial and statistical cost report data from Medicare certified hospitals and hospital/health care facility complexes beginning with hospital fiscal years ending on or after January 1, 1982. HCRIS also contains Title V and/or Title XIX data when hospitals are paid under the program(s) on a reasonable-cost basis and the Medicare Fiscal Intermediaries (FI's) are responsible for processing and settling their cost reports.

2. Section 223 Cost Limit File for SNF's and HHA's

This file contains data abstracted from cost reports submitted by SNF's and HHA's. The file is processed to develop the limits on Medicare payments to these institutions, as mandated by Congress.

E. Institutional Provider Identification and Certification

1. Provider of Services

As a by-product of the Medicare/Medicaid Provider certification process (MMACS), data which identify and characterize the participating institutional providers (hospitals, HHA's, etc.) are collected through the States and regions and recorded centrally in a continually updated data base. The data are used both administra- tively by HCFA and/or the PROs and for many statistical reports.

Additionally, the POS data are often merged with the billing records to enable tabulations of utilization by provider characteristics, as necessary.

2. Provider Specific File

The Provider Specific File is a component of the PRICER program used in the FIs' systems to compute individual DRG payments. It is needed in central office to supply essential data elements to the PPS recalibration processes and related PPS activities. It contains data elements computed by FIs to determine disproportionate share, indirect teaching payments and other PPS payments.

F. Beneficiary Entitlement and Demographics

Health Insurance Skeleton Write off (HISKEW) - 100 Percent

This file contains selected beneficiary entitlement and demographic information from the Health Insurance Master File such as age, sex, race, State, county, ZIP-Code, and entitlement. It is used to prepare an ongoing series of enrollment tabulations detailing the number and characteristics of Medicare beneficiaries, e.g., 1984 enrollment is prepared from the March 1985 HISKEW.

G. ESRD Program Data

End-Stage Renal Disease Program Management And Medical Information System (ESRD PMMIS)

The ESRD PMMIS is a uniform data base of national scope which contains basic medical and program management data elements related to the services provided by Medicare-approved ESRD facilities in the treatment of dialysis and kidney transplant patients:

The ESRD PMMIS is a comprehensive patient-based system which includes, by patient:

1. identifying characteristics
2. primary disease,
3. first date of ESRD care,
4. incidence records on dialysis and transplantation,
5. incidence of hospitalization and outpatient care, and
6. date and cause of death,

and an all inclusive facility-based system which includes, by Medicare-approved ESRD provider:

1. identification and certification characteristics, and
2. aggregate treatment surveys.

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Further information on the Medicare/Medicaid Statistical Files and data produced can be obtained by contacting the Division of Data Documentation and Release, OSDM, BDMS, HCFA, Room 3-A-10 Security Office Park Building, 6325 Security Blvd., Baltimore, Maryland 21207.

II. Enrollment

Introduction

This chapter describes the files used to obtain data on the entire Medicare population as well as selected subpopulations of individuals enrolled for Medicare benefits.

The Health Insurance Master File (HIM)

The Health Insurance Master File (HIM) identifies each person entitled to Medicare benefits. Entitlement may be for aged, disabled, or end stage renal disease whether a person is covered for hospital insurance benefits, supplementary insurance benefits, or both. Data on age, sex, race, and place of residence are obtained from this file.

For each person eligible for Medicare benefits, a record is maintained in the HIM file. Identification of each record is based on a claim number which consists of a primary beneficiary's Social Security or Railroad Retirement Board number and a one or two position beneficiary identification code (BIC). The BIC portion of the claim number describes the type of benefit that entitles individuals to Medicare coverage. The most common BIC's are "A" for a primary wage earner, "B" for a wife age 65 or older, and "D" for a widow age 65 or older.

The HIM file is updated daily for current maintenance and utilization information. Maintenance data consist of beneficiary enrollments and terminations, cross- references, changes of address, and field changes which are received from SSA's Master Beneficiary Record system or the Railroad Retirement Board. Utilization data consist of notices of hospital admission, queries, provider billing records and payment records received from intermediaries and carriers. Both the utilization and maintenance data are matched to the HIM for updating as part of HCFA's administrative process. This is illustrated in Exhibit A.

Health Insurance Skeleton Eligibility Write-off File

A skeletonized version of the HIM file, known as the Health Insurance Skeleton Eligibility Write-off (HISKEW), is created to tabulate enrollment data and to match against utilization data. The HISKEW file is produced quarterly from the HIM file.

A record format of this file, which includes a description of each field, is shown in Exhibit B. Approximately fifty million HISKEW records are created each quarterly processing period. This includes twenty million inactive (death) records.

Annual Enrollment Publication Tables

The annual enrollment tabulations showing the number of persons enrolled as of July 1 and the number of persons enrolled at any time in the year are produced from the HISKEW file created as of March of the following year. For example, 1988 data are produced from the March 1989 HISKEW file.

The tabulations contain counts of aged, disabled, and end stage renal disease enrollees by:

1. Type of coverage (HI, SMI, or both)
2. Age, race, and sex.
3. State of residence at time file is created.
4. Residence in Metropolitan Statistical Areas and Metropolitan and Non-Metropolitan counties.
5. Number of persons newly enrolled or terminated during the year of the data.

In addition, enrollees by county are shown as part of a tabulation containing enrollment and Medicare payment by State and county. Annual and quarterly data are tabulated and used for text tables, control tables, and utilization rates but are not routinely published.

Special Population Groups

1. Railroad Retirement Board (RRB) - A file of RRB beneficiaries entitled to Part A and/or Part B coverage is developed each year from the March HISKEW file. Enrollees are selected from this file based on RRB claim numbers. The entire HISKEW record is retained for each person selected. The file is used to obtain control data and can also be used to select records to study utilization of RRB enrollees.

2. State Buy-In Enrollment - A State, through a buy-in agreement with HCFA, may enroll needy aged and disabled persons eligible for either public assistance or medical assistance programs for Part B coverage. Once buy-in eligibility is established, enrollment of an individual is mandated. The individual cannot voluntarily terminate this coverage. A record for each enrollee is maintained in the HCFA Third Party Master file.

   This file is updated from records submitted by the State to HCFA and contains individuals to be added or deleted from its coverage group. Those records to be added to the group are screened against the HIM file to determine if the person is eligible for Part B benefits. Matched records are annotated to indicate buy-in status in the HIM file, added to the Third Party Master file, and billing of the State is initiated.

   Each year a State buy-in membership "ever enrolled" file population is developed from the Third Party Master File. Records are selected for this file if a person is a buy-in at any time in the specified calendar year. For each person selected, a record is created containing the following information:

   a. HI claim number

b. Date of birth

c. Sex

d. Race

e. State of residence at time file is created

f. Cross-reference claim number

g. Buy-in plan start date

h. Termination date

The file is summarized by age, race, sex, and State of residence. Tables are prepared presenting these data based on the number of buy-ins enrolled at any time in a year and as of July 1 of each year.

3. Group Practice Prepayment Plans (GPPP's) and Health Maintenance Organizations (HMO's) - The Group Health Plan System (GHP) maintains a membership file for those GPPP's and HMO's that deal directly with HCFA for purposes of reimbursement and to control posting of deductible pro-rata amounts of each plan member entitled to Part B coverage. One-twelfth of the Part B deductible is allotted to each member each month. Payment to each plan for Part B services rendered to members is on a cost basis for GPPP's dealing directly with HCFA. Payments to HMOs are generally made on the basis of the Adjusted Average Per Capita Cost (AAPCC) in each geographic area. A file of enrollees by plan is main-tained by HCFA and is called the Health Insurance Control Group Health Plan Master file (HCGPMSTER). The HCGPMSTER file is updated by records submitted to HCFA by a GPPP or HMO. Each record is screened for Part B eligibility against the HIM file and processed to the HCGPMSTER file.

Annual enrollment data are developed only for those plans dealing directly with HCFA. Records are selected from the HCGPMSTER file containing the following information:

a. HI claim number

b. Date of birth

c. Sex

d. Race

e. State of residence at time file is created

f. Cross-reference claim number

g. Plan start date

h. Termination date

i. GPPP or HMO plan number

This information is summarized by age, race, sex, GPPP or HMO plan, and State of residence. Tables are prepared presenting data on the number of persons enrolled at any time in a year and as of July 1 of each year.

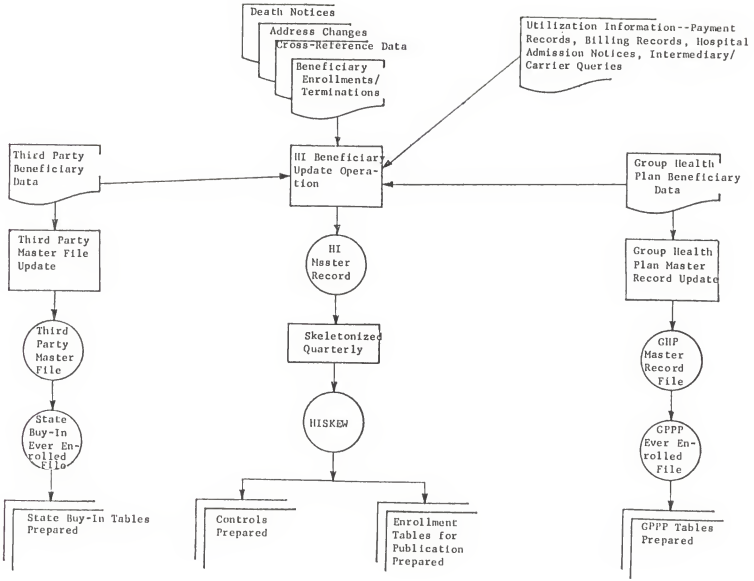


Exhibit A--Health Insurance Master Beneficiary Record--Enrollment and Utilization Maintenance

Exhibit A

Exhibit A

HISKEW Record Contents

	Information	Description
1.	HI Claim Number	Beneficiary's health insurance claim number
2.	Date of Birth	Julian date of beneficiary's birth
3.	Sex	-Male -Female -Unknown
4.	Race	-White -Black -Other -Unknown
5.	State Code of Residence	SSA Standard State code
6.	County Code of Residence	SSA Standard County code
7.	Cross-reference Claim Number	
8.	Original Reason for Entitlement	-OASI -DIB -Renal -Both DIB and Renal
9.	Current Reason for Entitlement	-OASI -DIB -Renal -Both DIB and Renal
10.	Dual Entitlement to SSA and RRB Benefits	-No -Yes
11.	Previous BIC	Beneficiary identification code used in the prior entitlement period
12.	Date of Death	Julian date of beneficiary's death

	Information	Description
13.	Current Part A Data a. Entitlement	Julian date
	b. Termination	Julian date
14.	Current Part B Data a. Entitlement	Julian date
	b. Termination	Julian date
15.	Coverage Code	-No coverage or deceased -Part A entitlement only -Part B entitlement only -Part A and B entitlement
16.	Termination Code A	Reason for termination to Part A entitlement: -Not terminated -Dead -Nonpayment of premium -Voluntary withdrawal -Entitlement under another claim number -Other termination
17.	Termination Code B	Reason for termination to Part B entitlement: -Not terminated -Dead -Nonpayment of premium -Voluntary withdrawal -Entitlement under another claim number -Other termination
18.	Prior Part A Data a. Entitlement	Julian date of latest prior entitlement
	b. Termination	Julian date of latest prior termination
19.	Prior Part B Data a. Entitlement	Julian date of latest prior entitlement
	b. Termination	Julian date of latest prior termination

Exhibit A

	Information	Description
20.	Bill Code	Coded to indicate party paying SMI -Individual -Public Assistance -Private Third Party -Civil Service
21.	ZIP Code of Residence	Actual
22.	Day 01 Indicator	Coded to indicate if beneficiary born on the first day of the month -Yes -No
23.	End Stage Renal Disease	Coded to indicate method of Indicator original notice of ESRD -No ESRD -MBR -HI -NIH -MBR/HI -MBR/NIH -HI/NIH -MBR/HI/NIH -OAS Clerical -MBR/OAS Clerical -HI/OAS Clerical -NIH/OAS Clerical -MBR/HI/OAS Clerical -MBR/NIH/OAS Clerical -HI/NIH/OAS Clerical -MBR/HI/NIH/OAS Clerical
24.	Century of Birth Indicator	-Prior Century -Current Century
25.	Other Entitlement Programs Indicator	-Coded to indicate primary payer if other than Medicare, i.e. Medicaid, Veterans Administration, Black Lung, and/or Workmen's Compensation entitlement
26.	Federal Employee Indicator	-Coded to indicate entitlement as a Federal Employee

III. Provider of Services Master File

Introduction

Institutional providers of service (hospitals, Long Term Care (LTC), Home Health Agency (HHA), etc.) participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing safe and effective care for the beneficiaries of the two programs. The certification procedure is conducted, under federal guidelines, by an Agency of the State where the institution is located. Final approval comes from the Health Care Financing Administration. After the initial certification, the qualifications of an institution are reviewed periodically, culminating in a decision to retain or terminate participation.

Source Documents and Input

The observations and decisions of the State agency surveyors, when applying the criteria which measure an institution's capacity to provide acceptable care as well as characteristics such as staffing, bed size, and services, are recorded in a forms package. The package is divided into two sets: the first, called the Survey Report Form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the particular institution. The second set comprises the source documents for the Provider of Services (POS) Master File and includes the certification and transmittal (Exhibit A) and the application (Exhibit B). A separate version of the application form is used for each type of provider (hospital, LTC, HHA, etc.).

The complete forms package (POS and SRF) is converted on a flow basis, on line to the central office update systems over wire transmission lines from the HCFA regional office (RO) or the State agency where the files of the source documents are maintained.

Update Mechanism and Quality Control Measures

The update cycle for the POS/SRF system is daily. The data entry and point-of-entry consistency checking are on-line. The data elements are keyed by the regional office or the State agency using terminals linked by wire to the HCFA Data Center. Data elements that fail consistency checks are earmarked for subsequent corrections by the RO or State agency. Nightly, each provider's data elements are sorted and assembled into a transaction record. Transactions without point-of-entry errors are matched/merged to the MMACS master file. In the matching process the transaction records undergo a second tier of consistency checks (comparison edits, e.g., inordinate increases/decreases in bed size or staffing). Only error-free transactions are updated to the master file; those with errors are held on a pending transaction file awaiting resolution by the RO.

Transactions that successfully entered the master file and rejected transactions are disposed of as follows: accretions without error are added to the data base; recertifications replace the associated earlier certifications, which are placed on a separate history file; corrections and termination actions overlay or add the prescribed data elements to the existing record. All new transactions, including those that failed to pass the consistency check, those that

failed to match the master data base, and those that were successfully applied to the master data base, are transmitted over the telecommunication network to the regional office. During this phase of the update system, a segment indicating errors discovered is appended to the transaction record. The entire process is set to a daily schedule so that the regions receive the disposition of the records they originally transmitted the morning following their transmission to central office.

In addition to the computer consistency checks, OSDM periodically performs a manual check of selected fields of transactions applied to the POS portion of the master data base. Periodic notes are sent to HSQB showing erroneous transactions which are not amenable to automated edits but are uncovered through comparison to other data sources.

Exhibits C and D detail the record contents of the POS portion for hospitals and LTC's respectively. Record contents for the HHA portion are shown in Exhibit E.

Dependent Systems and Outputs

The POS file is used to support a number of Health Insurance administrative data processing systems. These include the following:

1. RADARS

   RADARS is a rapid data retrieval system that is available to the regional offices and interested central office components. It permits lay users to extract current unit record listings and aggregated data through control statements entered via a terminal. Both SRF and POS data are available for extraction.

2. Provider Specific File

   The Provider Specific File is developed by the intermediaries for use in the hospital prospective payment system pricing mechanism. A reimbursement price is computed for an individual inpatient hospital stay depending on the Diagnosis Related Group (DRG) in which the stay is classified. The Provider Specific File is used in central office to support DRG recalibration; its completeness is measured by comparison to the POS file.

3. Federal Monitoring Surveys

   HCFA monitors the State agency performance in surveying health care facilities for Medicare/Medicaid certification. The POS/SRF information is used to support this activity, and the documentation of the monitoring is captured in the MMACS.

4. Chain Ownership Tracking

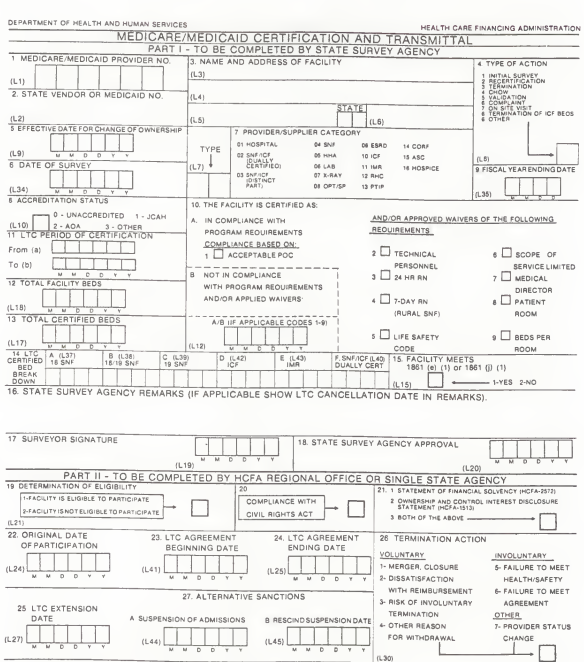
   This system records the identity of corporations/partnerships that own and operate chains of certified providers. Revised SRF forms will capture relevant data, and this will become a subsystem of the MMACS.

5. Case Control System

This system uses POS/SRF data to monitor Regional Office and State agency response to error correction and to control backlogs of surveys.

Recurring tabulations and analyses based on information from the POS file are published on an annual basis. Various listings and tabulations have been produced to satisfy requests from private organizations, other components of HCFA and DHHS, and the Congress. A version of the POS tape file is also prepared in a format suitable for use as input to the table generating software package, which is another means of servicing one-time special requests.

Exhibit A



DEPARTMENT OF HEALTH AND HUMAN SERVICES — HEALTH CARE FINANCING ADMINISTRATION

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY STATE SURVEY AGENCY

1 MEDICARE/MEDICAID PROVIDER NO. (L1)

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY (L3) (L4) STATE (L5) (L6)

4. TYPE OF ACTION
1 INITIAL SURVEY
2 RECERTIFICATION
3 TERMINATION
4 REVISIT
5 VALIDATION
6 COMPLAINT
7 ON SITE VISIT
8 TERMINATION OF ICF BEDS
9 OTHER (L8)

5 EFFECTIVE DATE FOR CHANGE OF OWNERSHIP (L9) M M D D Y Y

6 DATE OF SURVEY (L34) M M D D Y Y

7. PROVIDER/SUPPLIER CATEGORY
TYPE (L7)
01 HOSPITAL — 04 SNF — 08 ESRD — 14 CORF
02 SNF/ICF (DUALLY CERTIFIED) — 05 HHA — 10 ICF — 15 ASC
03 SNF/ICF (DISTINCT PART) — 06 LAB — 11 IMR — 16 HOSPICE
07 X-RAY — 12 RHC
08 OPT/SP — 13 PTIP

9 FISCAL YEAR ENDING DATE (L35) M M D D

8 ACCREDITATION STATUS (L10) 0 - UNACCREDITED 1 - JCAH 2 - AOA 3 - OTHER

10. THE FACILITY IS CERTIFIED AS:

A. IN COMPLIANCE WITH PROGRAM REQUIREMENTS
COMPLIANCE BASED ON:
1 ☐ ACCEPTABLE POC

B NOT IN COMPLIANCE WITH PROGRAM REQUIREMENTS AND/OR APPLIED WAIVERS:

A/B (IF APPLICABLE CODES 1-9) (L12) M M D D Y Y

AND/OR APPROVED WAIVERS OF THE FOLLOWING REQUIREMENTS:
2 ☐ TECHNICAL PERSONNEL
3 ☐ 24 HR RN
4 ☐ 7-DAY RN (RURAL SNF)
5 ☐ LIFE SAFETY CODE
6 ☐ SCOPE OF SERVICE LIMITED
7 ☐ MEDICAL DIRECTOR
8 ☐ PATIENT ROOM
9 ☐ BEDS PER ROOM

11. LTC PERIOD OF CERTIFICATION
From (a)
To (b)
M M D D Y Y

12 TOTAL FACILITY BEDS (L18) M M D D Y Y

13 TOTAL CERTIFIED BEDS (L17) M M D D Y Y

14. LTC CERTIFIED BED BREAK DOWN — A (L37) 18 SNF — B (L38) 18/19 SNF — C (L39) 19 SNF — D (L42) ICF — E (L43) IMR — F SNF/ICF (L40) DUALLY CERT

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1) (L15) ☐ ← 1-YES 2-NO

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE IN REMARKS).

17. SURVEYOR SIGNATURE (L19) M M D D Y Y

18. STATE SURVEY AGENCY APPROVAL (L20) M M D D Y Y

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19 DETERMINATION OF ELIGIBILITY (L21)
1-FACILITY IS ELIGIBLE TO PARTICIPATE
2-FACILITY IS NOT ELIGIBLE TO PARTICIPATE ☐

20 COMPLIANCE WITH CIVIL RIGHTS ACT ☐

21. 1 STATEMENT OF FINANCIAL SOLVENCY (HCFA-2572)
2 OWNERSHIP AND CONTROL INTEREST DISCLOSURE STATEMENT (HCFA-1513)
3 BOTH OF THE ABOVE ☐

22. ORIGINAL DATE OF PARTICIPATION (L24) M M D D Y Y

23. LTC AGREEMENT BEGINNING DATE (L41) M M D D Y Y

24. LTC AGREEMENT ENDING DATE (L25) M M D D Y Y

26 TERMINATION ACTION (L30) ☐
VOLUNTARY
1- MERGER, CLOSURE
2- DISSATISFACTION WITH REIMBURSEMENT
3- RISK OF INVOLUNTARY TERMINATION
4- OTHER REASON FOR WITHDRAWAL
INVOLUNTARY
5- FAILURE TO MEET HEALTH/SAFETY
6- FAILURE TO MEET AGREEMENT
OTHER
7- PROVIDER STATUS CHANGE

27. ALTERNATIVE SANCTIONS

25 LTC EXTENSION DATE (L27) M M D D Y Y

A SUSPENSION OF ADMISSIONS (L44) M M D D Y Y

B RESCIND SUSPENSION DATE (L45) M M D D Y Y

28 TERMINATION DATE (L28) M M D D Y Y

29 INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31 RO RECEIPT OF HCFA-1539 (L32) M M D D Y Y

32 DETERMINATION APPROVAL DATE (L33) M M D D Y Y

DETERMINATION APPROVAL

FORM HCFA-1539 (7-84) (DESTROY PRIOR EDITIONS)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0380

HOSPITAL REQUEST FOR CERTIFICATION IN THE MEDICARE/MEDICAID PROGRAM

(READ INSTRUCTION AND INFORMATION COLLECTION STATEMENT ON COVER SHEET PRIOR TO COMPLETION)

HOSPITALS ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH) OR THE AMERICAN OSTEOPATHIC ASSOCIATION (AOA) MAY ESTABLISH THEIR ELIGIBILITY TO PROVIDE SERVICES FOR REIMBURSEMENT UNDER THE PROGRAM BY SUBMITTING TO THE DESIGNATED STATE AGENCY INFORMATION ON THIS FORM. THE SIGNING OF THIS FORM ALSO AUTHORIZES THE JCAH OR THE AOA OR ANY OTHER NATIONAL ACCREDITING BODY RECOGNIZED BY THE SECRETARY AS MEETING THE CONDITIONS TO DISCLOSE TO ANY AUTHORIZED REPRESENTATIVE, EMPLOYEE OR AGENT OF THE HEALTH CARE FINANCING ADMINISTRATION A COPY OF THE HOSPITAL'S MOST RECENT ACCREDITATION SURVEY FOR OFFICIAL USE SOLELY IN CONNECTION WITH THE MEDICARE SAMPLE VALIDATION OR SUBSTANTIAL ALLEGATION SURVEY PROGRAM.

IT IS UNDERSTOOD THAT SURVEY INFORMATION DISCLOSED TO THE HEALTH CARE FINANCING ADMINISTRATION SHALL BE TREATED IN ACCORDANCE WITH THE RULE OF CONFIDENTIALITY AND DISCLOSURE CONTAINED IN §401.126(b) AND (c), PART 401 OF SUBCHAPTER A OF TITLE 42 OF THE CODE OF FEDERAL REGULATIONS. THE REGULATION ALLOWS NO DISCRETION ON THE PART OF THE HEALTH CARE FINANCING ADMINISTRATION TO DISCLOSE INFORMATION OBTAINED FROM THE JCAH OR AOA. MATERIALS WHICH WERE CONFIDENTIAL AND EXEMPTED FROM PUBLIC DISCLOSURE UNDER THIS PROCEDURE INCLUDE THE ACCREDITATION LETTER AND ACCOMPANYING RECOMMENDATION AND COMMENTS PREPARED BY THE JCAH OR AOA FOR THE BELOW—NAMED HOSPITAL'S ACCREDITATION SURVEY.

I. MEDICARE/MEDICAID PROVIDER NUMBER

☐☐☐☐☐☐

VENDOR NUMBER

☐

0 NOT ACCREDITED
1 JCAH ACCREDITED
2 AOA ACCREDITED
3 OTHER
4 BOTH JCAH AND AOA ACCREDITED

EFFECTIVE DATE OF ACCREDITATION

☐☐☐☐☐☐
MMDDYY (M1)

STATE/COUNTY CODE (M3)

EXPIRATION DATE OF ACCREDITATION

☐☐☐☐☐☐
MMDDYY (M2)

STATE REGION CODE (M4)

II. IDENTIFYING INFORMATION

NAME AND ADDRESS OF HOSPITAL (INCLUDE CITY/COUNTY, STATE, ZIP CODE)

FISCAL YEAR ENDING DATE
☐☐☐☐
MMDD

REQUEST TO ESTABLISH ELIGIBILITY IN:
1 MEDICARE 2 MEDICAID 3 BOTH (M5) ☐

CLIA I.D. NUMBER(S) (LIST THE CLIA NUMBERS FOR THE HOSPITAL LABORATORIES) (M6)

TELEPHONE NUMBER (INCLUDE AREA CODE) (M7)

RELATED PROVIDER NUMBER
☐☐☐☐☐☐ (M8)

III. TYPE OF HOSPITAL (ENTER ONE FROM COL. A THAT MOST ACCURATELY DESCRIBES THE HOSPITAL. CHECK ALL THAT APPLY IN COL. B.

A.
01 SHORT-TERM
02 LONG-TERM
03 CHRISTIAN SCIENCE SANITORIUM
04 PSYCHIATRIC
05 REHABILITATION
06 CHILDRENS
07 ALCOHOL AND/OR DRUG HOSPITAL
(M9) ☐☐

B.
1 ☐ REGIONAL REFERAL CENTER
2 ☐ MAYO CLINIC EXCEPTION
3 ☐ SOLE COMMUNITY
4 ☐ CANCER
5 ☐ PSYCHIATRIC UNIT
6 ☐ ALCOHOL/DRUG UNIT
7 ☐ REHABILITATION UNIT
8 ☐ HOSPITAL SWING BED (M10)

IV. PHYSICIAN TRAINING PROGRAMS

A. AFFILIATED WITH A MEDICAL SCHOOL
1 MAJOR
2 LIMITED
3 GRADUATE
4 NO AFFILIATION (M11) ☐

B. RESIDENT PROGRAMS APPROVED BY: (CHECK ALL THAT APPLY)
1 ☐ AMA
2 ☐ ADA
3 ☐ AOA
4 ☐ OTHER
5 ☐ NO PROGRAM

Form HCFA-1514 (4-86)

V. TYPE OF CONTROL (ENTER ONE)	VOLUNTARY NON-PROFIT 01 CHURCH 02 PRIVATE 03 OTHER (SPECIFY)	04 PROPRIETARY (M13) ☐☐	GOVERNMENT 05 FEDERAL 06 STATE 07 LOCAL 08 HOSPITAL DISTRICT OR AUTHORITY

VI. SERVICES PROVIDED: IF BY STAFF, ENTER A "1" IN THE BLOCK(s); IF UNDER ARRANGEMENT, ENTER A "2" IN THE BLOCK(s); IF PROVIDED BY BOTH, ENTER A "3" IN THE BLOCK. LEAVE BLANK IF THE SERVICE IS NOT PROVIDED. (M14)

1 ☐ ACUTE RENAL DIALYSIS	15 ☐ LABORATORY SERVICE (CLINICAL)	29 ☐ PEDIATRIC SERVICES
2 ☐ ALCOHOL AND/OR DRUG SERVICES	16 ☐ LABORATORY SERVICE (ANATOMICAL)	30 ☐ PHARMACY
3 ☐ ANESTHESIA SERVICES	17 ☐ LONG TERM CARE UNIT	31 ☐ PHYSICAL THERAPY SERVICES
4 ☐ BLOOD BANK	18 ☐ NEONATAL NURSERY	32 ☐ POSTOPERATIVE RECOVERY ROOMS
5 ☐ BURN CARE UNIT	19 ☐ NUCLEAR MEDICINE SERVICES	33 ☐ PSYCHIATRIC SERVICES
6 ☐ CHIROPRACTIC SERVICES	20 ☐ OBSTETRICS	34 ☐ RADIOLOGY SERVICES (DIAGNOSTIC)
7 ☐ CORONARY CARE UNIT	21 ☐ OCCUPATIONAL THERAPY SERVICES	35 ☐ RADIOLOGY SERVICES (THERAPEUTIC)
8 ☐ DENTAL SERVICES	22 ☐ OPEN HEART SURGERY FACILITIES	36 ☐ REHABILITATION SERVICES
9 ☐ DIETETIC SERVICES	23 ☐ OPERATING ROOM(s)	37 ☐ RESPIRATORY CARE SERVICES
10 ☐ EMERGENCY SERVICES (ORGANIZED)	24 ☐ OPTOMETRIC SERVICES	38 ☐ SELF CARE UNIT
11 ☐ HOME CARE PROGRAM	25 ☐ ORGAN BANK	39 ☐ SHOCK TRAUMA
12 ☐ HOSPICE	26 ☐ ORGAN TRANSPLANT SERVICES	40 ☐ SOCIAL SERVICES
13 ☐ INPATIENT SURGICAL SERVICES	27 ☐ OUTPATIENT SERVICES	41 ☐ SPEECH PATHOLOGY SERVICES
14 ☐ INTENSIVE CARE UNIT	28 ☐ OUTPATIENT SURGERY UNIT	

VII. NUMBER OF EMPLOYEES SALARIED BY HOSPITAL (FULL-TIME EQUIVALENT)

PHYSICIANS (SALARIED ONLY) ☐☐☐.☐☐ (M15)	LICENSED REGISTERED NURSES ☐☐☐.☐☐ (M16)	REGISTERED PHARMACISTS ☐☐☐.☐☐ (M17)	OCCUPATIONAL THERAPISTS ☐☐☐.☐☐ (M18)	PHYSICAL THERAPISTS ☐☐☐.☐☐ (M19)
RESIDENTS (PHYSICIANS) ☐☐☐.☐☐ (M20)	LICENSED PRACTICAL/LICENSED VOCATIONAL NURSES ☐☐☐.☐☐ (M21)	MEDICAL SOCIAL WORKERS ☐☐☐.☐☐ (M22)	SPEECH THERAPISTS ☐☐☐.☐☐ (M23)	PHYSICIAN ASSISTANTS ☐☐☐.☐☐ (M24)
INHALATION THERAPISTS ☐☐☐.☐☐ (M25)	DIETITIANS ☐☐☐.☐☐ (M26)	CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) ☐☐☐.☐☐ (M27)		ALL OTHERS ☐☐☐.☐☐ (M28)

WHOEVER KNOWINGLY OR WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS FORM MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE, OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY AS APPROPRIATE.

NAME OF AUTHORIZED REPRESENTATIVE (SIGNATURE)	TITLE (TYPED)	DATE ☐☐☐☐☐☐ M M D D Y Y (M29)

Provider of Services Hospital Record

	Information	Description
1.	Provider Number	Six position number identifies a specific facility. First two positions are the State code. Positions 3 and 4 identify the type of provider. 00-08--Short stay hospital 09--Multihospital complex 12--Alcohol/Drug hospital 18--Neighborhood health center 19--Christian Science 20-22--Long stay 30--Rehabilitation hospital 33--Children's hospital 40-44--Psychiatric D0-D9--Denied participation M0-M9--Not participating but meets Medicare definition of a hospital P0-P9--Not participating and does not meet Medicare definition of a hospital PPS Exempt S0-S9--Psychiatric unit PPS Exempt T0-T9--Rehabilitation unit PPS Exempt U0-U9--Swing-bed hospital (SNF) Positions 5 and 6 are numeric except for emergency and Federal hospitals which are coded E and F respectively, in the 6th position
2.	Intermediary Number	Number identifying the hospital's intermediary
3.	Effective Date of Participation	Date hospital entered Medicare program
4.	Date of Application	Date hospital initially applied for participation

Exhibit C

	Information	Description
5.	Surveyor Date	Date State surveyor completed examination of hospital
6.	State Survey Agency Approval Date	Date State approved survey of hospital
7.	Termination Date	Date hospital was terminated from program
8.	Determination Approval Date	Date Regional Office approved State findings
9.	Regional Office Receipt Date	Date Regional Office received survey
10.	Category of Provider	-General hospital -Psychiatric hospital -Christian Science
11.	Type of Action	-Initial certification -Recertification -Change of Ownership -Validation -Investigation -Complaint -Onsite visit
12.	Eligibility Determination	-Eligible -Ineligible to participate
13.	Title VI Compliance	-In compliance -No information
14.	Statement of Financial Solvency	-Settlement filed -No information
15.	Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary withdrawal -Failure to abide by agreement -Emergency hospital changed to full participation

	Information	Description
16.	Supplemental Information on Hospitals not in Full Compliance	-Emergency hospitals -Nonemergency hospital -Meets Medicare definition -Does not meet Medicare definition
17.	Status of Compliance with Program Requirements	-Coded indication showing basis for compliance to regulations -Information available upon request
18.	Certified Beds	Number of certified beds
19.	Total Beds	Total number of beds
20.	Name of Hospital	Name of Hospital
21.	Street Address	Street Address of hospital
22.	City and State	City and State of hospital
23.	ZIP Code	Zip Code of hospital
24.	Type of Hospital	-Short-term -Long-term -Psychiatric -Rehabilitation -Childrens -Alcohol and/or Drug Hospital -Christian Science
25.	Type of Control	-Voluntary nonprofit - Church -Voluntary nonprofit - Private -Other voluntary nonprofit -Proprietary -State -Local -Hospital district -Federal
26.	State Code of Hospital	SSA Standard State code
27.	County Code of Hospital	SSA Standard county code

Exhibit C

	Information	Description
28.	State Region Code of Hospital	Code assigned by States who divide themselves into regions
29.	PRO Code	Code identifying PRO area within State
30.	Authorized Date	Date application was completed
31.	Fiscal Year Ending Date	Date fiscal year ends
32.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one
33.	Previous Intermediary Number #2	Number of intermediary prior to previous intermediary #1
34.	FIPS MSA Code	Metropolitan Statisitical Area Code
35.	Intermediary Type	-HCFA -Blue Cross -Group Health -Commercial -State agency -Other
36.	Provider Number of Parent Organization	If the provider is owned by another provider, the owning provider's identification number is contained in this field.
37.	Previous Provider Number	If the institution changed status, e.g., long-term to short-term, the previous provider number is placed here.
38.	Status Code	-Accretion (initial) record -Change or correction including resurvey -Delete -Terminated
39.	Last Transaction Code	-Initial -Resurvey -Correction

	Information	Description
40.	Participation Code	Indicates type of program participation: -Medicare -Medicaid -Medicare and Medicaid -Nonparticipation
41.	Facility Group	Hospital
42.	Region Code	HCFA region
43.	HCFA MSA	Metropolitan Statistical Area code
44.	MSA Size Code	Code categorizing size by Census population
45.	Run Date of Accretion	Date initial record entered system
46.	Run Date of Last Transaction	Date last transaction entered system
47.	Change of Ownership Count	Number of times the facility has changed ownership
48.	Resurvey Count	Number of resurveys conducted under present ownership
49.	Prior Owner's Dates	-Change of ownership -Certification -Termination
50.	Survey Date	Date of survey
51.	Resident Programs Approved	Four position field. First position American Medical Association (AMA), second position American Dental Association (ADA), third position American Osteopathic Association (AOA), fourth position "other." Each position coded for approval, not approved or no program.

Exhibit C

Information	Description
52. Facilities and Services	Forty-one position field. Each position coded as follows:
1- Acute renal dialysis 2- Alcohol/drug services 3- Anesthesia 4- Blood Bank 5- Burn care unit 6- Chiropractic Services 7- Coronary care unit department 8- Dental services 9- Dietetic services 10- Emergency department 11- Home care unit 12- Hospice 13- Inpatient surgical/services 14- Intensive care unit 15- Laboratory (clinical) 16- Laboratory (anatomical) 17- Long term care unit 18- Neonatal nursery 19- Nuclear medicine 20- Obstetrics 21- Occupational Therapy 22- Open heart surgery 23- Operating room(s) 24- Optometric services 25- Organ bank 26- Organ transplant services 27- Outpatient services 28- Outpatient surgery unit 29- Pediatric services 30- Pharmacy 31- Physical Therapy services 32- Postoperative recovery room 33- Psychiatric services 34- Radiology (diagnostic) 35- Radiology (therapeutic) 36- Rehabilitation services 37- Respiratory care services 38- Self care unit	-Provided by staff -Provided under arrangement -Provided by both -Not Provided

	Information	Description
52.	Facilities and Services (con.) 39- Shock trauma 40- Social Services 41- Speech Pathology services	
53.	Salaried Physicians	Number of physicians salaried by hospitals
54.	Number of Employees by Type Physicians (salaried only) Licensed Registered nurse Licensed practical/vocational nurses Registered Pharmacist Medical Social worker Occupational therapist Speech therapist Physical therapist Residents (physicians) Physician Assistants Inhalation therapists Dietitians Certified registered nurse Anesthetist Other employees Total staff	Number of employees for each type of employee
55.	Affiliation with a Medical School	-Major -Limited -Graduate -No affiliation
56.	Accreditation Verified	-JCAH accredited -AOA accredited -Not accredited or no information
57.	Change in Accreditation	-Gained accreditation -Lost JCAH accreditation -Lost AOA accreditation -No change

Exhibit C

	Information	Description
58.	Date Approved for Emergency	Approval date for hospitals with "E" in Services sixth position of provider number
59.	JCAH Survey Date	Date surveyed by the Joint Commission on Accreditation of Hospitals
60.	Indicator of State and Survey of JCAH/AOA Hospitals	-Sample validation -Monitoring hospital -Complaint investigation -Monitoring because of complaint results
61.	Emergency Election Code (Emergency Hospitals only)	-Emergency hospital does not elect participation -Emergency hospital elects participation
62.	Type of PPS Hospital Limitation	- Regional referral center - Mayo Clinic exception - Sole community - Cancer - Psychiatric unit - Alcohol/drug unit - Rehabilitation unit - Hospital swing bed

Provider of Services Long Term Care Record

	Information	Description
1.	Provider Number	Six position number identifies a specific facility. First two positions are State code. Positions 3 and 4 are coded as follows: -Medicare participating SNF's -Christian Science -Medicaid only participating SNF's -Medicaid participating ICF's -Medicaid participating IMR's Positions 5 and 6 are always numeric
2.	Intermediary Number	Number identifying the Medicare intermediary for a participating LTC
3.	Effective Date of Participation	Date LTC entered Medicare Program
4.	Date of Application	Date LTC initially applied for participation
5.	Surveyor Date	Date State surveyor completed examination of LTC
6.	State Survey Agency Approval Date	Date State agency approved survey of LTC
7.	Termination or Nonrenewing Date	Date LTC was terminated from Medicare program or contract was not renewed
8.	Determination Approval Date	Date Regional Office approved State findings
9.	Regional Office Receipt Date	Date Regional Office received survey

Exhibit D

	Information	Description
10.	Category of Provider	-SNF -SNF/ICF (dually certified) -SNF/ICF (distinct part) -Christian Science -ICF (Intermediate Care Facility) -IMR (Institution for the Mentally Retarded)
11.	Type of Action	-Initial certification -Recertification -Change of ownership -Validation -Investigation -Complaint -Onsite visit -Termination of ICF beds
12.	Eligibility Determination	-Eligible -Ineligible to participate
13.	Title VI Compliance	-In compliance -No information
14.	Statement of Financial Solvency	-Statement filed -No Information
15.	Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary, no longer meets requirements -Failure to meet health/safety -Failure to abide by agreement -LTC status change -Provider status change
16.	Supplemental Information on Facilities not in Full Compliance	-Meets definition of a LTC -Does not meet definition -Part of facility meets definition of an LTC
17.	Status of Compliance with Program Requirements	Coded indicators showing basis for compliance to regulations defining LTC's. Details available upon request.

	Information	Description
18.	Certified Beds	Coded to indicate LTC category -Medicaid SNF -Medicare/Medicaid SNF -Medicare SNF -ICF -SNF/ICF swing beds -IMR -LTC category will be followed by number of beds certified for that facility.
19.	Total Beds	
20.	Name of Facility	Name of Facility
21.	Street Address	Street Address of Facility
22.	City and State	City and State of Facility
23.	ZIP Code	ZIP Code of Facility
24.	Type of LTC Facility	-SNF -ICF -SNF/ICF -IMR
25.	Type of Control	-Church (nonprofit) -Private (nonprofit) -Other nonprofit -Proprietary -Federal -State -Local
26.	State Code of LTC	SSA Standard State code
27.	County Code of LTC	SSA Standard county code
28.	State Region Code of LTC	Code assigned by States who divide themselves into regions
29.	PRO Code	Professional Review Organization Code

Exhibit D

	Information	Description
30.	Authorized Date	Date application was completed
31.	Fiscal Year Ending Date	Date provider's fiscal year ends
32.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one
33.	Previous Intermediary Number #2	Number of intermediary prior to previous intermediary #1
34.	Intermediary Type	-HCFA -Blue Cross -Group Health -Commercial -State Agency -Other
35.	Hospital Based Indicator	Coded to indicate if facility is hospital based
36.	Provider Number of Parent Organization	If the provider is owned by another provider, the owning provider's identification number is contained in this field
37.	Previous Provider Number	If the institution changed status, e.g., IMR to SNF, the previous provider number is placed here
38.	Status Code	-Accretion (initial) record change or correction including resurvey -Delete -Terminated
39.	Last Transaction Code	-Initial -Resurvey -Correction
40.	Participation Code	-Medicare -Medicaid -Medicare and Medicaid -Nonparticipation

	Information	Description
41.	Facility Group	Long-term care
42.	Region	HCFA region
43.	HCFA MSA	Metropolitan Statistical Area code
44.	MSA Size Code	Code categorizing size by Census population
45.	Run Date of Accretion	Date initial record entered system
46.	Run Date of Last Transaction	Date last transaction entered system
47.	Change of Ownership Count	Number of times the facility has changed ownership
48.	Resurvey Count	Number of surveys conducted under present ownership
49.	Survey Date	Date on site certification survey was conducted
50.	Prior Owner's Date (YYMMDD)	-Change of ownership -Certification -Termination
51.	Program Eligibility	-Medicare -Medicaid -Both

Exhibit D

	Information	Description
52.	Services	Nineteen position field. Each position coded as follows:
	1-Nursing	-Provided by staff
	2-Physical therapy	-Provided under arrangement
	3-Outpatient physical therapy	-Provided by both
	4-Occupational therapy	-Not provided
	5-Speech pathology	
	6-Outpatient speech pathology	
	7-Social services	
	8-Patient activities	
	9-Pharmacy	
	10-Clinical laboratory	
	11-Diagnostic X-Ray	
	12-Administration and storage of blood	
	13-Dentistry	
	14-Podiatry	
	15-Ophthalmology	
	16-Psychological services	
	17-Dietary services	
	18-Housekeeping services	
	19-Other	
53.	Completion Date for ICF Life Safety Code Compliance	
54.	SNF/ICF Period of Certification	
	From Date	
	To Date	
55.	SNF/ICF Cancellation Date	Date (YY-MM-DD) contract with SNF/ICF is cancelled
56.	Agreement Ending Date	Date RO designates as date Medicare contract ends
57.	Cancellation Date	Date (YY-MM-DD) RO designates for cancellation of Medicare contract

	Information	Description
58.	SNF/ICF Agreement Date	Date beyond normal ending date granted to correct deficiencies
59.	Distinct Part Indicator	-Facility contains a certified distinct part -Facility does not contain a certified distinct part
60.	Number of Beds--Total Facility	Certified and noncertified beds
61.	Number of Employees-- Registered professional nurses Licensed practical nurses Nurses aides/orderlies All others Total staff	Full time equivalents
62.	Medicaid Termination Date	Date LTC was terminated from Medicaid participation
63.	Number of Title XVIII Certified Beds	Number of beds certified for Medicare beneficiaries
64.	Number of Title XVIII and XIX Certified Beds	Title XVIII is Medicare, Title XIX is Medicaid. Number of beds certified for Medicare and Medicaid beneficiaries
65.	Number of Title XIX Certified Beds	Number of beds certified for Medicaid beneficiaries
66.	Number of SNF/ICF Swing Beds	Same beds certified for either SNF or ICF utilization depending on status of occupant
67.	Agreement Beginning Date	Date agreement to participate was executed with HCFA

Exhibit E

Provider of Services Home Health Agency Record

	Information	Description
1.	Provider Number	Six position number identifies a specific facility. First two positions are the State code. Positions 3 and 4 are coded as follows: -individual HHA -HHA subunit of non-profit or proprietary -subunit of a State-wide HHA Positions 5 and 6 are numeric
2.	Intermediary Number	Number identifying the HHA's intermediary
3.	Effective Date of Participation	Date HHA entered Medicare program
4.	Date of Application	Date when HHA initially applied for participation
5.	Surveyor Date	Date State surveyor completed examination of HHA
6.	State Agency Survey Approval Date	Date State agency approved survey of HHA
7.	Termination Date	Date HHA was terminated from the program
8.	Determination Approval Date	Date Regional Office approved State findings
9.	Regional Office Receipt Date	Date Regional Office received survey
10.	Type of Action	-Initial certification -Recertification -Change of ownership -Validation -Investigation -Complaint -Onsite visit

	Information	Description
11.	Eligibility Determination	-Eligible -Ineligible to participate
12.	Title VI Compliance	-In Compliance -No Information
13.	Statement of Financial Solvency	-Statement filed -No information
14.	Reason for Termination Code	-Voluntary closure, merger -Voluntary withdrawal -Involuntary -Failure to abide by agreement -Failure to meet health/safety -Provider status change
15.	Name of Facility	Name of Facility
16.	Street Address	Street Address of Facility
17.	City and State	City and State of Facility
18.	ZIP Code	ZIP Code of Facility
19.	Type of HHA	-Visiting Nurse Association -Combination government and voluntary agency -Official health agency -Rehabilitation facility based program -Hospital based program -SNF based program -Proprietary -Private nonprofit
20.	Type of Control	-Voluntary nonprofit other than church -Church -State government -Local government -Combination government and voluntary -Proprietary -Private nonprofit

Exhibit E

	Information	Description
21.	State Code of HHA	SSA standard state code
22.	County Code of HHA	SSA standard county code
23.	State Region Code	Code assigned by States who divide themselves into regions
24.	PRO Code	
25.	Authorized Date	Date application was completed
26.	Fiscal Year Ending Date	Date fiscal year ends
27.	Previous Intermediary Number #1	Number of intermediary immediately prior to present one
28.	Previous Intermediary Number #2	Number of intermediary prior to previous intermediary #1
29.	Switch Date of Intermediary	Date of last intermediary change
30.	Intermediary Type	-HCFA -Blue Cross -Group Health -Commercial -State Agency -Other
31.	Provider Number of Parent Organization	If the provider is owned by another provider, the owning provider's identification number is contained in this field.
32.	Previous Provider Number	If the institution changes status, e.g., SNF to HHA, the previous provider number is placed here.
33.	Status Code	-Accretion (initial) record change or correction including resurvey -Delete -Terminated

	Information	Description
34.	Last Transaction Code	-Initial -Resurvey -Correction
35.	Participation Code	-Medicare -Medicaid -Medicare and Medicaid -Nonparticipation
36.	Facility Group	Home Health Agency
37.	Region	HCFA Region
38.	MSA	Metropolitan Statistical Area
39.	MSA Size Code	Code categorizing size by census population
40.	Run Date of Accretion	Date initial record entered system
41.	Run Date of Last Transaction	Date last transaction entered system
42.	Change of Ownership Count	Number of times the facility has changed ownership
43.	Resurvey Count	Number of resurveys conducted under present ownership
44.	Prior Owner's Dates	-CHOW (Change of Ownership) date -Certification date -Termination date
45.	Survey Date	Date on site certification survey was conducted
46.	Medicaid-State Vendor Number	
47.	Area of Operation	-Less than county wide -Single county -Multicounty -Unknown

Exhibit E

	Information	Description
48.	Number of Employees by Type	Full time equivalents
	Registered professional nurse	
	Licensed practical nurse	
	Qualified physical therapist	
	Qualified occupational therapist	
	Qualified speech pathologist or audiologist	
	Home health aides	
	Other	
	Total staff	
49.	Services	Twelve position field. Each position coded as follows:
	1-Nursing Care	-Provided by staff
	2-Physical therapy	-Provided under arrangement
	3-Occupational therapy	-Provided by both
	4-Speech therapy	-Not provided
	5-Medical social services	
	6-Home health aide	
	7-Interns and residents	
	8-Nutritional guidance	
	9-Pharmaceutical service	
	10-Appliances and equipment service	
	11-Vocational guidance	
	12-Other	

IV. Bill Records from Institutional Providers

Introduction

This chapter describes the statistical files created from bills submitted by institutional providers. These are primarily hospitals, skilled nursing facilities, home health agencies, rural health clinics, and renal dialysis facilities. They provide Medicare services for both Part A and/or Part B of the program. They submit bills to HCFA by way of the Part A intermediary selected by them to process their claims.

HCFA has the basic responsibility for controlling and monitoring intermediary/carrier payments to beneficiaries or providers. Intermediaries and carriers are responsible for verifying a beneficiary's eligibility, type of coverage, deductible, etc., before a claim is paid. When a beneficiary is admitted as an inpatient to a hospital or skilled nursing facility, the provider must determine if hospital entitlement exists. The provider notifies its servicing intermediary of the admission at the time it submits a bill. The intermediary then submits the admission data to HCFA. HCFA's query system processes these queries against its Health Insurance Master file to determine the beneficiary's status. If the beneficiary is covered, HCFA will then prepare an admission notice for subsequent in-house processing and will also transmit a query reply that is used by the intermediary to update its own history files.

Preparation of the Query Record

A query (admission) record must be submitted by the intermediary for all Medicare beneficiary inpatient or skilled nursing facility (SNF) admissions. This is needed by HCFA to maintain accurate benefit period (spell-of-illness) information.

The notice of an inpatient hospital admission, when transmitted to HCFA results in recording the beginning of services in the patient's utilization record; i.e., the creation of an "open item". This open item remains on the individual's record until it is closed by a discharge bill. See Exhibit A for contents of the Admission Record.

Queries are also received by HCFA for Supplementary Medical Insurance (SMI) claims. However, after the carrier has verified the beneficiary's entitlement and deductible status, if the deductible is met, subsequent claims are not normally queried. SMI claims involving non-inpatient psychiatric or physical therapy expenses must be queried unless the carrier has information in file from a previous reply indicating that the applicable money limits have been reached. Since current statistics are not being obtained from SMI queries, this manual does not cover those records.

Approximately 11,500,000 admission notice (or query) records are received annually.

One Hundred Percent Files

Provider bills submitted by intermediaries to HCFA enter the statistical system only after they have been updated to the Health Insurance Master record (HIM). When the bill records are updated to the HIM, the enrollees' demographic characteristics such as age, sex, race, and residence are appended. These records, which now contain both billing and demographic information, are accumulated weekly and then entered into the statistical system.

Exhibits B, C, D, and E contain record formats of the bill records which comprise the one hundred percent bill files. The bill records are extracts of the provider submitted HCFA-1450 (UB-82, Uniform Bill) shown as exhibit F. The record formats are as follow:

Exhibit B - Inpatient Hospital and Skilled Nursing Facility Record Format. This record contains information from Part A inpatient hospital and inpatient skilled nursing facility bills.

Exhibit C - Home Health Agency Record Format. This record contains Part A and Part B HHA billing information. If a bill contains both Part A and Part B information, two separate tape records are prepared.

Exhibit D - Outpatient Bill Record Format. This record contains Part B outpatient billing information. It is also used for rural health clinic and outpatient renal dialysis services.

Exhibit E - Hospice Record Format. This record contains information on hospice services rendered.

The one hundred percent provider bill files, along with the one hundred percent file of payment records, are used to prepare control tables and a series of monthly, quarterly, semi-annual, and annual tabulations. Some tables are based on all of the records and others are based on samples which are inflated.

Diagnostic and Surgical Procedure Data

The one hundred percent utilization bill files described above, contain diagnostic and surgical procedure codes. These are reported directly by the intermediary from provider submitted codes. The information on each type of bill is as follows:

Inpatient Hospital - Principal diagnosis and principal surgical procedures (if any)

Inpatient SNF - Admitting diagnosis

Outpatient Hospital - Nature of illness and surgical procedure (if any)

Home Health Agency - (A or B) - Diagnosis

Prior to October 1983, the diagnostic and surgical information was reported in narrative form (up to 45 characters for diagnosis and 41 characters for surgery) for samples of bills only. Only one diagnosis and surgical procedure (if any) was coded. The coding system in use since 1979 is ICD-9-CM Volumes I and II for diagnosis and ICD-9-CM, Volume III, for surgical procedures. For services before 1971, ICDA-7 was used; and from 1971 - 1978, it was ICDA-8.

In October 1983, hospitals were required to report only ICD-9-CM codes for inpatient hospital bills. Narratives were no longer permitted. Inpatient hospital bills were to contain codes for the principal diagnosis and up to four additional diagnoses and principal surgical procedure and up to two additional surgical procedures, if any. Inpatient hospital bills also were required to contain a Diagnosis Related Group (DRG) number to determine reimbursement for prospective payment. The DRG is assigned by the fiscal intermediary by processing the billing information through a computer program called GROUPER.

Medicare bills other than inpatient hospital, outpatient, home health, and skilled nursing facility were still reporting either narratives or codes until April 1985 when only ICD-9- CM codes were permitted.beginning July 1, 1987 outpatient surgery codes were required to be reported using HCFA Common Procedure Coding System (HCPCS) codes.

Annual Volume of Records for the One Hundred Percent Files - 1985

1. Inpatient Bills - 11 Million
2. Home Health Agency Bills - 5 Million
3. Outpatient Bills - 42 Million
4. Skilled Nursing Facility Bills - 0.8 Million

These bill records, along with approximately 360 million Part B Payment Records, are on monthly files based on month processed in HCFA. Each monthly file contains all types of bills in sequence by processing week and Health Insurance Claim Number and comprises approximately 60 reels of magnetic tape.

Exhibit A

Part A (Query) Admission Notice Contents

	Information	Description
1.	HI Claim Number	Beneficiary's Health Insurance claim number
2.	Admission Date	Julian date beneficiary admitted as inpatient to hospital or SNF
3.	Query Code	-Initial request -Delete previous request -Follow-up request -Status request
4.	Beneficiary Name a. Surname b. First Initial c. Middle Initial	First six letters of surname
5.	Date of Birth	Julian date of beneficiary's birth
6.	Sex	-Male -Female -Unknown
7.	Type of Facility	-Christian Science SNF -Psychiatric -TB -General Care -Regular SNF
8.	Receipt Date	Date admission notice was received into the HCFA EDP system
9.	Process Date	Date admission notice was processed
10.	Disposition Code	This code identifies the type of reply made by HCFA to the intermediary. Codes basically indicate approval, rejection, qualified approval, or just an acknowledgement of the receipt of the admission notice.

	Information	Description
11.	Reason for Entitlement Trailer Code	-No disability or ESRD involvement -Beneficiary currently insured due to disability. No ESRD involvement. -Beneficiary currently insured due solely to ESRD -Beneficiary currently insured for disability with prior or current ESRD involvement -Beneficiary currently insured due to age (OASDI) with prior or current ESRD involvement -Beneficiary currently entitled to Part A coverage due to buy-in provisions with prior or current ESRD involvement
12.	Intermediary Number	Intermediary's identification number
13.	Provider Number	Identification number of the provider submitting the claim

Exhibit B

Inpatient Hospital and Skilled Nursing Facility Bill Records

	Information	Description
1.	Health Insurance Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alpha-numeric suffix (BIC) identifies the claimant.
2.	Beneficiary Identification Code	Identifies beneficiary's (BIC) relationship to primary beneficiary. For bill and stay records this field is an equatable BIC.
3.	Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number
4.	Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5.	State Code of Residence	SSA standard State code
6.	County Code of Residence	SSA standard county code
7.	Date of Birth	Julian date. Date of beneficiary's birth (from Master Record)
8.	Sex Code	Code which identifies the sex of the beneficiary (from Master Record) -Unknown -Male -Female
9.	Race Code	Code which identifies the race of the beneficiary (from Master Record) -Unknown -White -Black -Other
10.	ZIP Code of Residence	Beneficiary's ZIP code from Master Record

	Information	Description
11.	Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12.	Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits. -OASI -DIB -Renal -DIB and Renal
13.	Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal
14.	End Stage Renal Disease Indicator	This code indicates the source of the notice of end stage renal disease -No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH and Clerical

Exhibit B

Information	Description
15. HMO Indicator	-HMO involvement -No HMO involvement
16. Number of HMO Periods	Counter for the number of HMO periods -Actual number of periods -Period number nine or greater
17. HMO Effective Date	Julian start date of HMO period
18. HMO Termination Date	Julian termination date of HMO period
19. HMO Number	Plan number for Health Maintenance Organization
20. HMO Option Code	For lock-in beneficiaries: -HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills -HMO to process all Part A and Part B bills For non-lock-in beneficiaries: -HCFA to process all provider bills. -HMO to process only in-plan Part A and in-area Part B bills
21. Bill Covers Period	Statement covers period, Julian date
a. From Date	Beginning date of bill
b. Through Date	Ending date of bill
22. Query Code	Code indicating status of bill: -Credit adjustment -Interim bill -Final bill -Discharge bill -Discharge notice -Debit adjustment

Information	Description
23. Transaction Code	Indicates the type of institutional provider -Christian Science SNF -Psychiatric hospital -Tuberculosis hospital -General Care hospital -Regular SNF -Home Health Agency -Outpatient -Comprehensive Outpatient Rehabilitation Facility -Hospice
24. Adjustment Code	Code indicating a cancel only bill: -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other
25. Spider Indicator	-Bill submitted through on-line system, otherwise blank
26. Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
27. Provider Number	Identifier for the provider of services
28. Special Unit Code	Derived from the provider number 3rd digit, which has been reset to zero. A value other than blank indicates a part of a short stay hospital not covered by PPS. -Provider number not changed -Psychiatric unit -Rehabilitation unit -Swing-bed hospital designation

Exhibit B

	Information	Description
29.	Intermediary Number	Identification number of the intermediary processing the bill
30.	Date Approved	Julian date bill approved by intermediary
31.	Date Forwarded	Julian date bill received by intermediary
32.	Date of Admission	Julian date admitted to institution
33.	Patient Status Code	Possible Values -Discharged -Died -Still patient
34.	Discharge Date	Julian date of discharge from institution
35.	Date of Death	Julian date of beneficiary's death reported on the bill
36.	Total Covered Days	
37.	Cost Report Days	Number of days which would have been Medicare covered days if another primary payor were not involved or if a beneficiary had fewer days available than were needed by a PPS bill
38.	Lifetime Reserve Days	Number of lifetime reserve days used this stay
39.	Professional Component Charges	Charges for medical professionals that the hospital or third party payors require to be separately identified. As required by TEFRA.

Information	Description
40. Primary Payor Code	Information about a primary payor (with Medicare as secondary payor) The following are the valid codes: -Working aged beneficiary/spouse with an employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Worker's Compensation -PHS or other federal agency -Disabled beneficiary under age 65 with LGHP -Black Lung -Veterans Administration -Medicare is primary payor
41. Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor, zero for Medicare.
42. Non-Covered Ancillary Charges	Non-covered charges for all ancillaries
43. Inpatient Deductible	Deductible to be paid by beneficiary
44. Coinsurance Days and Amount a. Days b. Rate per day c. Total Amount	
45. Total Deductions	Represents total non-covered charges, total deductibles, and coinsurance amounts
46. Blood Deductible Pints	Number of pints of whole blood or units of packed red cells furnished for which the patient is responsible

Exhibit B

Information	Description
47. Blood Deductible Charge/Pint	Zeroes if no charges for blood
48. Blood Deductible Charges	Blood deductible pints x charge per pint
49. Total Blood Deductions	
50. Blood Code	Constant A
51. Blood Pints Furnished	Number of pints of whole blood or units of packed red cells furnished
52. Blood Pints Replaced	
53. Blood Pints Not Replaced	
54. Blood Charge/Pint	Zero if no charge for blood
55. Total Blood Charges	
56. Total Blood Non-Covered Charges	
57. Non-Covered	From Date - Beginning Julian date of stay
58. Non-Covered Through Date	Ending Julian date of stay
59. Open Item From Date	From Julian date of open item used to link the bill to an earlier spell
60. Open Item Through Date	Latest Julian date of open item used to link the bill to a more current spell
61. Non-Payment Code	Code indicating a cancel only bill -Covered Workmens' Compensation -Benefits exhausted -Custodial care -Non-covered -Payment refused -Workmens' Compensation
62. Total Charges	Total charges for all accommodations and services

Information	Description
63. Provider Payment Amount	Reimbursement amount from bill. Payment amount for interim payments made to the hospital. Final payment is made on a cost basis based on the cost report each hospital is required to prepare at the end of their fiscal year. Beginning October 1983, for most hospitals, this amount is based on the DRG.
64. Diagnosis Data	
a. Number of Diagnosis Codes	
b. Principal Diagnosis Code	Coding Based on ICD-9-CM, Volumes I and II. Identifies the condition chiefly responsible for the patient's hospitalization.
c. Additional Diagnosis	This field may be repeated for up to four additional diagnoses.

NOTE: For SNF bills Item 64 is used for admitting diagnosis.

65. Surgery Data	
a. Number of Surgery Codes	
b. Principal Surgery	Coding based on ICD-9-CM, Volume III
c. Additional Surgery	This field may be repeated for up to two additional surgical procedures.
d. Date of Surgery	Julian date on which surgery was performed
66. Non-Covered Charges	

Exhibit B

Information	Description
67. ESRD Indicator	-Other than transplant -Transplant, unspecified donor -Transplant, living donor -Transplant, cadaveric donor
68. Qualifying Dates	Julian date of qualifying stay for SNF
a. From Date	Beginning Julian date of stay
b. To Date	Ending Julian date of stay
69. DRG Code	Code assigned to indicate diagnosis related group to which this claim belongs for payment purposes
70. Discharge Destination	-To home, self care -To short-term hospital -To SNF -To ICF -To other type facility -To home, health service care -Left against medical advice -Died -Still patient
71. DRG Outlier Code	-No outlier -Day outlier -Cost outlier
72. Date Guarantee of Payment Began	Julian date
73. Date UR Notice Received	Julian date
74. Date Active Care Ended	Julian date
75. Date Benefits Exhausted	Julian date
76. Outlier Amount	Additional payment amount approved due to an outlier situation

Information	Description
77. HMO Paid/Readmission Indicator	-Not paid by an HMO -Paid by an HMO -Readmission within 7 days of a prior discharge -Both conditions present
78. Value Code	Description and codes are at the end of the Glossary.
79. Value Code Amount	Amount related to the value code
80. Revenue Center Code	Code identifying each service (RCC) incurred during the billing period
81. Units	Number of units related to the RCC
82. Service Date	Month and Day - May be zeroes
83. Rate	For RCC accommodations
84. Charges	Total charges for this RCC
85. Non-Covered Charges	Non-covered charges for this RCC
86. Medical Record Number	Assigned by provider to patient records
87. Patient Control Number	Unique alphanumeric number assigned by provider for this beneficiary
88. Type of Admission	-Emergency -Urgent -Elective -Unknown
89. Source of Admission	For Admissions: -Physician referral -Clinic referral -HMO referral -Transfer from hospital -Transfer from SNF -Transfer from another health care facility

Exhibit B

Information	Description
90. Admitting Diagnosis	-Code from ICD-9-CM Volumes I and II, reason for admission, may be different from principal diagnosis

NOTE: Items 81-86 are repeated for each revenue center code.

Home Health Agency Bill Records

Information	Description
1. Health Insurance Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alpha-numeric suffix (BIC) identifies the claimant.
2. Beneficiary Identification Code	Identifies beneficiary's (BIC) relationship to primary beneficiary. For bill and stay records this field is an equatable BIC.
3. Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number
4. Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5. State Code of Residence	SSA standard State code
6. County Code of Residence	SSA standard county code
7. Date of Birth	Julian date of beneficiary's birth (from Master Record)
8. Sex Code	Code which identifies the sex of the beneficiary (from Master Record) -Unknown -Male -Female
9. Race Code	Code which identifies the race of the beneficiary (from Master Record) -Unknown -White -Black -Other
10. ZIP Code of Residence	Beneficiary's ZIP code from Master Record

Exhibit C

Information	Description
11. Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12. Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal
13. Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal
14. End Stage Renal Disease Indicator	This code indicates the source of the notice of end stage renal disease. -No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH and Clerical

Information	Description
15. HMO Indicator	-HMO involvement -No HMO involvement
16. Number of HMO Periods	Counter for the number of HMO periods -Actual number of periods -Period number nine or greater
17. HMO Effective Date	Julian start date of HMO Period
18. HMO Termination Date	Julian termination date of HMO period
19. HMO Number	Plan number for Health Maintenance Organization
20. HMO Option Code	For lock-in beneficiaries: -HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills -HMO to process all Part A and Part B bills For non-lock-in beneficiaries: -HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills
21. Query Code	Code indicating status of bill: -Credit adjustment -Interim bill -Final bill -Discharge bill -Discharge notice -Debit adjustment

Exhibit C

Information	Description
22. Transaction Code	Indicates the type of institutional provider -Christian Science SNF -Psychiatric hospital -Tuberculosis hospital -General Care hospital -Regular SNF -Home Health Agency -Outpatient -Comprehensive Outpatient Rehabilitation Facility -Hospice
23. Adjustment Code	Code indicating a cancel only bill: -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other
24. Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
25. Provider Number	Identifier for the provider of services
26. Record Identification Code	-Home Health Part A -Home Health Part B
27. Intermediary Number	Identification number of the intermediary processing the bill
28. Date Approved	Julian date bill approved by intermediary
29. Date Forwarded	Julian date bill received by intermediary
30. Date of Admission	Julian date care began

	Information	Description
31.	Patient Status Code	Possible Values: -Discharged -Died -Still patient -Visits exhausted
32.	Patient Status Date	Julian date, based on record with latest status record with latest status date
33.	Date of Death	Julian date of beneficiary's death as reported on the bill
34.	Date Plan Established	Julian date beginning or review date of home health plan
35.	From Date	Date of first service
36.	To Date	Julian date of last service
37.	Total Visits	Total visits for all services
38.	Total Visit Charges	Total charges for all services
39.	Deductible	
40.	Primary Payor Code	Information about a primary payor (with Medicare as secondary payor) The following are the valid codes: -Working aged beneficiary/spouse with an employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Workers Compensation -PHS or other federal agency -Disabled beneficiary under age 65 with LGHP

Exhibit C

	Information	Description
40.	Primary Payor Code (cont.)	-Black Lung -Veterans Administration -Medicare is primary payor
41.	Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor, zero for Medicare
42.	Coinsurance Amount	
43.	Number of Units	Number of units of service
44.	Charge/Unit of Service	Dollars - Charge for each unit of service
45.	Total Charges	Total charges for all service
46.	Provider Payment Amount	Reimbursement amount from bill
47.	Non-Covered Charges	
48.	Number of Diagnosis Codes	Number of diagnostic codes
49.	Diagnosis Code	ICD-9-CM, Volumes I and II
50.	Value Code	Description and codes are contained in the Glossary.
51.	Value Code Amount	Amount related to the value code
52.	Revenue Center Code (RCC)	Code identifying each service incurred during the billing period
53.	Units	Number of units related to the RCC
54.	Service Date	Month and day, - May be zeroes, related to RCC
55.	Rate	Rate per unit related to RCC
56.	Covered Charges	Total charges for this code

NOTE: Items 52-56 are repeated for each revenue center code.

Outpatient Bill Record

	Information	Description
1.	Health Insurance Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alpha-numeric suffix (BIC) identifies the claimant.
2.	Beneficiary Identification Code	Identifies beneficiary's (BIC) relationship to primary beneficiary. For bill and stay records this field is an equatable BIC.
3.	Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number
4.	Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5.	State Code of Residence	SSA standard State code
6.	County Code of Residence	SSA standard county code
7.	Date of Birth	Julian date of beneficiary's birth (from Master Record)
8.	Sex Code	Code which identifies the sex of the beneficiary (from Master Record) -Unknown -Male -Female
9.	Race Code	Code which identifies the race of the beneficiary (from Master Record) -Unknown -White -Black -Other
10.	ZIP Code of Residence	Beneficiary's ZIP code from Master Record

Exhibit D

Information	Description
11. Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12. Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal
13. Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal
14. End Stage Renal Disease Indicator	This code indicates the source of the notice of end stage renal disease -No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH and Clerical

Information	Description
15. HMO Indicator	-HMO involvement -No HMO involvement
16. Number of HMO Periods	Counter for the number of HMO periods -Actual number of periods -Period number nine or greater
17. HMO Effective Date	Julian start date of HMO period
18. HMO Termination Date	Julian termination date of HMO period
19. HMO Number	Plan number for Health Maintenance Organization
20. HMO Option Code	For lock-in beneficiaries: -HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills -HMO to process all Part A and Part B bills For non-lock-in beneficiaries: -HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills
21. Bill Covers Period	Statement covers period, Julian date
a. First Service	Julian date of first service
b. Last service	Julian date of last service
22. Query Code	Code indicating status of bill: -Credit adjustment -Interim bill -Final bill -Discharge bill -Discharge notice -Debit adjustment

Exhibit D

Information	Description
23. Transaction Code	Indicates the type of institutional provider -Outpatient Psychiatric Hospital -Outpatient Tuberculosis Hospital -Outpatient General Care Hospital -Outpatient SNF -Home Health Agency -Comprehensive Health Center -Clinic Rehabilitation Center -Rural Health Clinic -Satelite Dialysis Facility -Limited Care Facility -Hospice
24. Adjustment Code	Code indicating a cancel only bill: -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other
25. Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
26. Provider Number	Identifier for the provider of services
27. Intermediary Number	Identification number of the intermediary processing the bill
28. Date Approved	Julian date bill approved by intermediary
29. Date Forwarded	Julian date bill received by intermediary
30. Patient Status Code	Possible Values: -Discharged -Died -Still patient

	Information	Description
31.	Patient Status Date	Julian date relating to patient status code field.
32.	Date of Death	Julian date of beneficiary's death as reported on the bill.
33.	Primary Payor Code	Information about a primary payor (with Medicare as secondary payor) The following are the valid codes: -Working aged beneficiary/spouse with an employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Workers Compensation -PHS or other federal agency -Disabled Beneficiary under age 65 with LGHP -Black Lung -Veterans Administration -Medicare is primary payor
34.	Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor, zero for Medicare
35.	Value Code	Description and codes are contained in the Glossary.
36.	Value Code Amount	Amount related to the value code
37.	Revenue Center Code	Code identifying each service incurred during the billing period
38.	HCPCS Procedure Code	Clinical laboratory charges for non-inpatient services reimbursed at 100 percent

Exhibit D

	Information	Description
39.	Units	
40.	Service Date	Month and day - May be zeroes.
41.	Rate	
42.	Covered Charges	
43.	Professional Pathology Charges	Amount paid for hospital inpatient or other professional components
44.	Professional Radiology Charges	Amount paid for hospital inpatient or other professional components
45.	Professional Other Charges	Amount paid for hospital inpatient or other professional components
46.	Blood Deductible	
47.	Blood Deductible Pints	Number of pints of whole blood or units of packed red cells
48.	Cash Deductible	
49.	Coinsurance Amount	Comprehensive Outpatient Rehabilitation Facility (CORF) only
50.	Blood Pints Furnished	Number of pints of whole blood or units of packed red cells furnished
51.	Blood Pints Replaced	
52.	Blood Pints Not Replaced	
53.	Blood Charge/Pint	Zero if no charge for blood, UNIBILL - Constant zero
54.	Patient Paid for Blood Deductible	
55.	ESRD Method of Reimbursement	-Not ESRD -Method 1 -Method 2

	Information	Description
56.	Special Service Code	-Professional component -Durable medical equipment -Home dialysis equipment -Pneumococcal vaccine
57.	Charges Excluded From Deductible	UNIBILL only, accumulation of amounts for revenue center charges which are not subject to deductible.
58.	Number of Diagnosis Codes	Number of diagnostic codes reported
59.	Diagnosis Code	Nature of illness code based on ICD-9-CM, Volumes I and II
60.	Additional Diagnoses	Up to 4 additional ICD-9-CM Volumes I and II diagnosis codes
61.	Date of Surgery	Julian date of beneficiary's surgery
62.	Number of Surgical Procedures	Number of surgical procedure codes reported
63.	Surgical Procedure Code	Procedure codes based on ICD-9-CM, Volume III. Effective July 1, 1987 HCPCS codes replace the ICD-9-CM Volume III codes for outpatient surgery.
64.	Additional Surgery	Same as field 63, up to two additional codes.
65.	Patient Paid Amount	
66.	Amount Paid to Provider	
67.	Amount Paid to Patient	
68.	Date Benefits Exhausted	Julian date
69.	Date Plan Terminated	Julian date

Exhibit D

	Information	Description
70.	Total Charges	Total charges for all services
71.	Provider Payment Amount	Sum of amount paid to provider and amount paid to patient fields

Hospice Bill Records

Information	Description
1. Health Insurance Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alpha-numeric suffix (BIC) identifies the claimant.
2. Beneficiary Identification Code	Identifies beneficiary's (BIC) relationship to primary beneficiary. For bill and stay records this field is an equatable BIC.
3. Cross Reference Claim Number	Beneficiary's cross-reference Health Insurance claim number
4. Beneficiary's Name a. Surname b. Initial - 1st c. Initial - 2nd	
5. State Code of Residence	SSA standard State code
6. County Code of Residence	SSA standard county code
7. Date of Birth	Julian date of beneficiary's birth (from Master Record)
8. Sex Code	Code which identifies the sex of the beneficiary (from Master Record) -Unknown -Male -Female
9. Race Code	Code which identifies the race of the beneficiary (from Master Record) -Unknown -White -Black -Other
10. ZIP Code of Residence	Beneficiary's ZIP code from Master Record

Exhibit E

Information	Description
11. Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12. Current Reason for Entitlement	Indicates the reason for the beneficiary's current entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal
13. Original Reason for Entitlement	Indicates the reason for the beneficiary's original entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal
14. End Stage Renal Disease	This code indicates the Indicator source of the notice of end stage renal disease. -No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH and Clerical

Information	Description
15. HMO Indicator	-HMO involvement -No HMO involvement
16. Number of HMO Periods	Counter for the number of HMO periods -Actual number of periods -Period number nine or greater
17. HMO Effective Date	Julian start date of HMO period, initialized to zeroes
18. HMO Termination Date	Julian termination date of HMO period, initialized to zeroes
19. HMO Number	Plan number for Health Maintenance Organization, initialized zeroes
20. HMO Option Code	For lock-in beneficiaries: -HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills -HMO to process all Part A and Part B bills For non-lock-in beneficiaries: -HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills
21. Bill Covers Period	Statement covers period, Julian dates
a. From Date	Beginning date of bill
b. Through Date	Ending date of bill
22. Query Code	Code indicating status of bill: -Credit adjustment -Interim bill -Final bill -Discharge bill -Discharge notice -Debit adjustment

Exhibit E

	Information	Description
23.	Transaction Code	Indicates the type of institutional provider -Christian Science SNF -Psychiatric Hospital -Tuberculosis Hospital -General Care Hospital -Regular SNF -Home Health Agency -Outpatient -Comprehensive Outpatient Rehabilitation Facility (PATBILL only) -Hospice
24.	Adjustment Code	Code indicating a cancel only bill: -Coverage transfer -Plan transfer -Scramble -Duplicate billing -Other
25.	Employment Related	-Complementary insurance -Employment related -Both complementary insurance and employment related -Neither complementary insurance nor employment related
26.	Provider Number	Identifier for the provider of service
27.	Intermediary Number	Identification number of the intermediary processing the bill
28.	Date Approved	Julian date bill approved by intermediary
29.	Date Forwarded	Julian date bill received by intermediary
30.	Date of Admission	Julian date admitted to institution

Information	Description
31. Patient Status Code	Possible Values -Discharged -Died -Still patient -Visits exhausted (HHA only)
32. Discharge Date	Julian date of discharge from institution
33. Date of Death	Julian Date of death of beneficiary
34. Total Covered Days	
35. Cost Report Days	Number of days which would have been Medicare covered days if another primary payer were not involved or if a beneficiary had fewer days available than were needed by a PPS bill
36. Primary Payor Code	Information about a primary payor (with Medicare as secondary payor) The following are the valid codes: -Working aged beneficiary/spouse with an employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Workers' Compensation including black lung -PHS or other federal agency -Disabled beneficiary under age 65 with LGHP -Black Lung -Veterans Administration -Medicare is primary payor

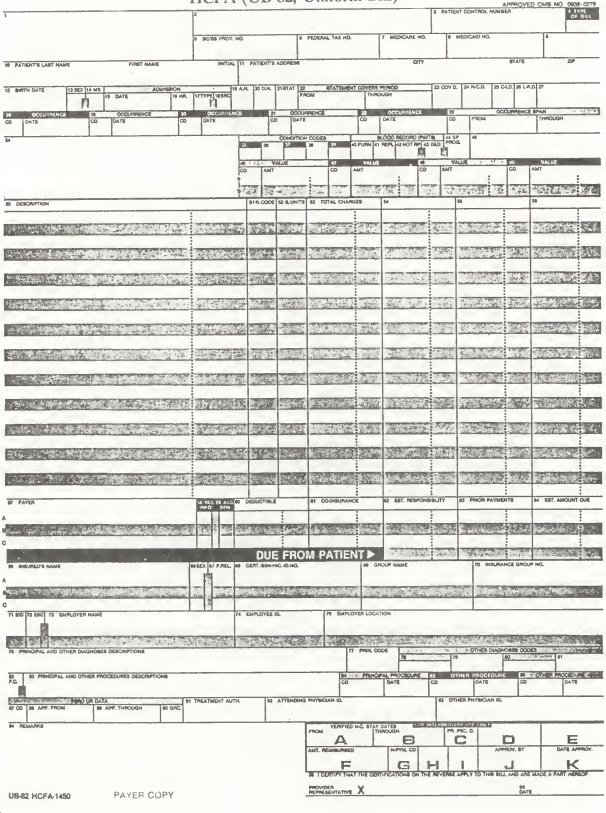
Exhibit E

	Information	Description
37.	Primary Payor Amount	The amount of Medicare covered expenses paid by primary payor, zero for Medicare.
38.	Total Charges	Total charges for all accommodations and services
39.	Provider Payment Amount	Payment amount for bill
40.	Value Code	Description and codes are contained in the Glossary.
41.	Value Code Amount	Amount related to the value code
42.	Revenue Center Code	Code identifying each service incurred during the billing period
43.	HCPCS Procedure Code	
44.	Units	
45.	Service Date	Month and day, - May be zeroes
46.	Rate	
47.	Covered Charges	
48.	Hospice Start Date	Julian date - From ancillary entitlement record on HDHIMA file
49.	Stay Days	Total days for this bill (through date minus from date)
50.	Hospice Period Number	From HDHIMA file

Information	Description
51. Discharge Destination	-To home, self care -To short term hospital -To SNF -To ICF -To other type facility -To home, health service care -Left against medical advice -Still patient -Died at home -Died in a medical institution -Place of death unknown
52. Number of Services HSP	Number of Hospice care services
53. Number of Diagnosis Codes	Number of diagnostic codes reported on bill
54. Diagnosis Code	ICD-9-CM, Volumes I and II, left justified, blank filled

Exhibit F

HCFA (UB-82, Uniform Bill)



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V. Stay Records

Introduction

The Inpatient Hospital Stay Record contains information about every beneficiary's stay in a hospital from admission through discharge. Stay records are used to compile a significant portion of the health insurance utilization statistics such as the annual short-stay hospital tabulations, current utilization tabulations, and Medicare Provider Analysis and Review (MEDPAR) files. The MEDPAR file contains utilization information from bills, demographic information about the enrollee, and provider identifier. The file contains about 11,000,000 records per year.

Billing and Demographic Information

The basic input for the hospital stay records are bills for inpatient hospital services submitted to HCFA via intermediaries for Medicare payments. Bills which have cleared the administrative process at HCFA and have been updated to the Health Insurance Master File (HIM) are entered into the statistical system. When the bill record is updated to the HIM, the enrollee's demographic characteristics such as date of birth, sex, race, and State, county and zip code of residence are appended to it. The record sent for statistical processing contains both the billing information and a person's demographic characteristics. Chapter IV describes the contents of these records.

Inpatient Hospital Stay Records

All bills submitted for the same hospital stay are sorted and summarized, creating a bill summary record. When the bill summary indicates that the patient has been discharged (i.e., a discharge bill has been received), a stay record showing information from date of admission to date of discharge is created. A single bill, in approximately 95 percent of all cases, will result in a completed stay record. If the patient has not been discharged, the bill summary remains on an orbiting bill summary file until the discharge information is received. The stay record is in the same format as the inpatient hospital and skilled nursing facility record format shown in Chapter IV, Exhibit B.

Bills used for creating stay records contain a principal diagnosis code and up to four additional diagnosis codes. The five digit diagnostic code is assigned from the ICD-9-CM, Volumes I and II. If surgery has been performed, a principal surgical procedure code, up to two additional surgical procedure codes, and dates of surgery are also shown on the bill. The four digit surgical procedure code is assigned from the ICD-9-CM, Volume III. There is also a Diagnosis Related Group (DRG) number.

Skilled Nursing Facility (SNF) Stay Records

Stay records are also prepared for stays in Skilled Nursing Facilities. The SNF stay record is essentially the same as the inpatient hospital stay record. SNF stay records contain an admitting diagnosis instead of a principal diagnosis, and there is no surgery. The five digit admitting diagnosis code is assigned from the ICD-9-CM, Volumes I and II as is the

inpatient hospital bill principal diagnosis. There are also dates of admission and discharge of the qualifying hospital stay. The record format is the same as the inpatient hospital and skilled nursing facility record format shown in Chapter IV, Exhibit B.

Derivative Files

Exhibit A contains the contents of the Medicare Provider Analysis and Review (MEDPAR) record. It is derived from the inpatient hospital stay record. Each record contains selected items of information from the hospital stay record. Three files of MEDPAR records are prepared every 3 months the current year and 2 previous years. For example, the files created at the end of July 1989 contain discharges from 1987 through 1989. Annually, approximately 11.0 million records are created.

A Public Use version of the MEDPAR file (Exhibit B) is also available which contains selected data fields extracted from the MEDPAR records. Personal identifiers are omitted to enable use for non-HCFA purposes. The MEDPAR and the MEDPAR Public Use File are available in either fiscal or calendar year format.

MEDPAR File

	Information	Description
1.	HI Claim Number	Actual Number
2.	Age	Age as of last birthday on date of admission
3.	Sex	Sex code obtained from HI Master Record -Unknown -Male -Female
4.	Race	Race code obtained from HI Master Record -Unknown -White -Black -Other
5.	Medicare Status Code	Code to show reason for beneficiary's entitlement. -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
6.	State and County of Residence	SSA state and county code of residence
7.	ZIP Code of Residence	Actual code
8.	Day of Admission	Day of admission to provider -Sunday -Monday -Tuesday -Wednesday -Thursday -Friday -Saturday

Exhibit A

	Information	Description
9.	Discharge Status	Discharge Status -Alive -Dead
10.	HMO Readmission Indicator	-Not paid by HMO -Paid by HMO -Readmission within 7 days -Both conditions present
11.	PPS Indicator	Hospital being paid under a prospective payment system -Yes -No
12.	Provider Number	Identification number of provider
13.	Provider Code	Code to identify components of inpatient hospitals. -Original provider number as is -Psychiatric Unit -Rehabilitation Unit -Swing-Bed Hospital Designation -Alcohol Drug Unit
14.	Date of Admission	Julian date of admission
15.	Date of Discharge	Julian date of discharge
16.	Length of Stay	Date of discharge minus date of admission. If difference was 0, it was made 1.
17.	Covered Days	The number of days covered by Medicare
18.	Coinsurance Days	The inpatient medicare days occurring after the 60th day and before the 91st day in a single spell of illness
19.	Coinsurance Amount	Total amount for coinsurance

	Information	Description
20.	Inpatient Deductible	Deductible to be paid by patient
21.	Lifetime Reserve Days Used	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
22.	Total Charges	- Dollars only
23.	Covered Charges	- Dollars only
24.	Provider Payment Amount	- Dollars only
25.	Intensive Care Days	Days
26.	Coronary Care Days	Days
27.	Total Accommodation Charges	- Dollars only
28.	Total Departmental (Ancillary) Charges	- Dollars only (Summary Total)
29.	Intensive Care Charges	- Dollars only
30.	Coronary Care Charges	- Dollars only
31.	Operating Room Charges	- Dollars only
32.	Pharmacy Charges	- Dollars only
33.	Laboratory Charges	- Dollars only
34.	Radiology Charges	- Dollars only
35.	Supplies Charges	- Dollars only
36.	Anesthesia Charges	- Dollars only
37.	Inhalation Therapy	- Dollars only

Exhibit A

	Information	Description
38.	Outpatient Service	- Dollars only
39.	Blood Administration	- Dollars only
40.	Physical Therapy	- Dollars only
41.	Occupational Therapy	- Dollars only
42.	Speech Pathology	- Dollars only
43.	Other Charges	- Dollars only
44.	Diagnostic Data	Principal and up to four additional ICD-9-CM Volumes I and II diagnosis codes
	A. Number of Codes	Number of diagnosis codes
	B. Codes	Five position diagnosis codes; left justified, blank filled
45.	Surgery Indication	-Yes -No
46.	Inpatient Data (Surgical Data)	
	A. Surgical Date 1	Julian date 1st surgical procedure performed, zero if date not submitted
	B. Number of Codes	Number of surgical procedure codes
	C. Codes	Four position ICD-9-CM volume III surgical procedure codes; left justified, blank filled
	D. Surgical Date 2	Julian date 2nd surgical procedure performed, zero if date not submitted.
	E. Surgical Date 3	Julian date 3rd surgical procedure performed, zero if date not submitted.

	Information	Description
46.	Inpatient Data(Surgical Data)(con.)	
	SNF Data (Inpatient Surgical Data Area Redefined)	
	A. SNF date benefits exhausted	Julian date
	B. Filler	Reserved
	C. SNF Indicator	Value "SNF" Indicating SNF Record
	D. Filler (Occurs Two Times)	Reserved
	E. Dates of Qualifying Stay for SNF Facility	
	1. From Date 2. Through Date	Beginning Julian date of stay Ending Julian date of stay
47.	Blood Furnished (pints)	2-digit pints of whole blood or units of packed red cells
48.	Original BIC	This is the original BIC of the HIC number on the bill or payment record, which has been replaced with the equatable BIC.
49.	DRG Code	Code assigned to indicate the diagnosis related group to which this claim belongs for payment purposes
50.	Discharge Destination	Code to indicate destination of patient at time of discharge: -To home, self care -To short-term hospital -To SNF -To ICF -To other type facility -To home, health service care -Left against medical advice -Died -Still patient

Exhibit A

	Information	Description
51.	Outlier Code	Code indicating whether covered days or charges exceed the threshold values. Also used to code DRG information. -No outlier -Day outlier -Cost outlier -Valid DRG received from the intermediary -HCFA developed DRG -HCFA developed DRG using Patient -Status code -Not groupable
52.	Primary Payor Code	Code indicating who is primarily responsible for payment -Working aged beneficiary/spouse with employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault or any liability insurance -Worker's Compensation -PHS or other federal agency -Disabled beneficiary under age 65 with LGHP -Black Lung -Veterans Administration -Medicare is primary payor
53.	Type of Admission	Code indicating type of Admission -Emergency -Urgent -Elective -Unknown

	Information	Description
54.	Source of Admission	Code indicating source of admission: -Physician referral -Clinic referral -HMO referral -Transfer from hospital -Transfer from SNF -Transfer from another health care facility -Emergency room -Court/Law enforcement -Unknown
55.	Professional Components	Dollars only - Amount for hospital inpatient or other professional components
56.	Blood Charges	Dollars only - Charges for blood usage
57.	Unibill Indicator	Code indicating unibill format or not unibill format
58.	Primary Payor Amount	Medicare covered amount paid by primary payor, zero filled for Medicare
59.	Intermediary Number	Identification number of intermediary processing the bill
60.	Query Code	Code indicating type of bill submitted: -Credit Adjustment -Interim -Final -Discharge Notice -Debit Adjustment
61.	Active Care Ended Date	Julian date active inpatient hospital care ended if prior to date of discharge
62.	Outlier Amount	Additional payment amount approved due to an outlier situation
63.	Kidney Acquisition Charge	Total charges, including living donor charges, for the acquisition of a kidney for use in transplantation

Exhibit A

	Information	Description
64.	Outlier Days	Number of outlier days used
65.	DRG Price	The DRG price is determined by the following formula: Provider payment amount + Primary payor amount + Coinsurance amount + Inpatient deductible + Blood deductible non-covered charges - Outlier amount = DRG Price
66.	New DRG Code	The DRG from the GROUPER in effect at the time the MEDPAR is produced rather than the GROUPER in effect at date of service. Grouper 3.0 (May 1, 1986 September 30, 1986). Grouper 4.0 (October 1,1986). Grouper 5.0 (November 11,1987)
67.	New Outlier Days	Number of outlier days used based on the threshold in effect at the time the MEDPAR is produced
68.	HI Master Date of Death	Julian date taken from the HI Master File
69.	HI Master Date of Death Indicator	-Nonvalid Date of Death -Valid Date of Death
70.	New Change Indicator	-No Change to Record -New Record -Change Record

Information	Description
71. Total Pass Through	
a. Total Per Diem	-Covered days multiplied by the provider's per diem rate
b. Total Indirect Medical Education Amount(IME)	-Provider payment amount multiplied by IME Cost Rate
c. Kidney Acquisition Charge	-For DRG 302 Only this field is coded at central office using kidney acquisition costs from cost reports to compute an average cost per case to enter in stays with a kidney transplant DRG

Exhibit A

MEDPAR Public Use File

Information	Description
1. Diagnosis Related Group (DRG)	Code assigned to indicate the DRG to which this claim belongs for payment purposes
2. Major Diagnostic Categories (MDC)	Identifies the category of which the DRG is a member
3. Medicare Status Code	Code indicating the reason for entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
4. Day of Admission	Day of admission to provider: -Sunday -Monday -Tuesday -Wednesday -Thursday -Friday -Saturday
5. Discharge Status	Discharge Status: -Alive -Dead
6. Metropolitan/Nonmetropolitan	Codes to identify metropolitan areas designated by Statistical Area (MSA/NONMSA) Executive Office of Management and Budget (OMB) Codes that have populations of 50,000 or greater
7. Length of Stay	Date of discharge minus date of admission. If difference is 0, it is made 1.
8. Covered Days	The number of days covered by Medicare

	Information	Description
9.	Total Charges	Dollars only
10.	Covered Charges	Dollars only
11.	Intensive Care and Coronary Care Days	Total of days spent in intensive care and coronary care units during this hospital stay
12.	Total Departmental (Ancillary) Charges	Dollars only
13.	Operating Room Charges	Dollars only
14.	Pharmacy Charges	Dollars only
15.	Laboratory Charges	Dollars only
16.	Radiology Charges	Dollars only
17.	Supply Charges	Dollars only
18.	Anesthesia Charges	Dollars only
19.	Inhalation Therapy Charges	Dollars only
20.	Number of Diagnosis Codes	Number of ICD-9-CM Volumes I and II diagnosis codes occurring in the record
21.	Principal Diagnosis	ICD-9-CM diagnosis code identifying the condition chiefly responsible for the patient's admission to the hospital
22.	Diagnosis Two	Additional diagnosis
23.	Diagnosis Three	Additional diagnosis
24.	Diagnosis Four	Additional diagnosis
25.	Diagnosis Five	Additional diagnosis

Exhibit A

	Information	Description
26.	Surgery Indicator	Code indicating whether or not a was surgery performed -Yes -No
27.	Number of Surgical Procedure Codes	Number of ICD-9-CM, Volume III surgical procedure codes appearing in the record
28.	Principal Surgical Procedure	Surgery performed that is most related to the principal diagnosis
29.	Surgery Two	Additional surgery
30.	Surgery Three	Additional surgery
31.	Age	Age as of last birthday on date of admission
32.	Sex	Sex of the beneficiary -Unknown -Male -Female
33.	Blood Pints Furnished	Number of pints of whole blood or packed red cells furnished whether or not replaced

VI. Part B Payment Records

Introduction

Part B Supplementary Medical Insurance (SMI) benefits are payable for physician's services, home health service visits, outpatient hospital services, and other medical services and supplies. Medical insurance benefits for home health services and outpatient hospital services, where the bills are processed by a Part A Intermediary, are covered in other chapters. This chapter relates to physician services and other medical services and supplies where the requests for payment are processed by Part B carriers. Payments generally are based on charges and are subject to both an annual deductible amount and a coinsurance amount. Specific medical services not subject to any deductible or coinsurance amounts are detailed in the "Preparation of the Payment Record" portion of this chapter. Payments for services can be made directly to physicians (or other suppliers of medical services) if they accept assignment, or to the beneficiary, if assignment is not accepted by the physician or supplier. Forms HCFA-1500 and 1490S are the basic Part B claim forms used by either the patient or physician (supplier) to claim reimbursement. (Form HCFA-1490 was used prior to Form HCFA-1500 or HCFA-1490S). See Exhibits C and D for copies of these forms.

HCFA, the Agency responsibile for administering the SMI program, enters into agreements with public or private organizations called carriers, which help administer the medical insurance benefit claims process. These contractor organizations, using HCFA coverage and claims processing guidelines, determine which services are covered, the amounts payable, and make payment to providers and beneficiaries. They also communicate utilization and benefit information to HCFA.

Carriers prepare and send to HCFA a payment record for every bill for which payment is made under the Supplementary Medical Insurance Program. The payment record has very important administrative and statistical uses.

1. To provide current information on supplementary medical insurance benefit payments and to make possible the preparation of a variety of operating statistics.

2. To provide information to assist in the conduct of administrative and fiscal audits of carrier operations.

3. To draw samples for special ad hoc studies focusing on specific groups of physicians and suppliers, specific types of services, and specific geographic areas.

4. To provide current information to assist in preparing a variety of program statistics tabulations.

5. To provide a 100 percent base from which either samples or 100 percent files may be used to provide data needed for actuarial calculations.

Because of their importance, all carriers prepare payment records uniformly in accordance with the instructions contained in the Medicare Carrier's Manual and transmit them promptly to HCFA.

The Office of Health Program Systems (OHPS) handles the automated processing of payment records and is responsible for determining the appropriateness of payments made by carriers based on a computer analysis of the data contained in the payment records and the related Health Insurance Master Record data. Entitlement to benefits during the period in which expenses were incurred, deductible satisfied, proper computation of the payment amount, etc., are monitored in the data edit/validation processes. Inconsistencies detected are returned to the carriers for investigation, correction, and resubmission. A "suspense" file of all rejected records is maintained by OHPS to ensure their return. As these records are corrected and returned, they are deleted from the suspense file and processed in the utilization routines.

Preparation of the Payment Record

A payment record is prepared by a carrier after the amount of payment on an individual bill has been determined and payment has been made to the physician or the beneficiary (or on his or her behalf). A "bill" is defined as a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or single supplier. A payment record is submitted for every bill for which payment is made. Payment records are also prepared for bills when the primary payor is other than Medicare. Situations will arise--e.g., overpayments or incomplete information--when carriers determine that the amount reimbursed for a specific bill is incorrect and needs to be adjusted. In those instances, a corrected payment record is submitted.

The number of bills on a request for payment is determined by the number of different beneficiary-physician (or supplier) relationships represented. For example, a request for payment accompanied by itemized statements from only one physician or supplier constitutes only one bill, regardless of the number of occasions of service. A request for payment accompanied by itemized statements from two physicians or suppliers constitutes two bills, etc.

The definition of a payment record is generally the same as that of a bill. A request for payment from a beneficiary accompanied by one or more itemized statements from the same physician requires preparation of only one payment record. On the other hand, if a beneficiary had accumulated and submitted itemized statements from two physicians for medical treatment and from an orthotist for fitting and purchase of an artificial leg and payment was made for the services of all three, the carrier prepares three payment records--one for each physician's services and one for the orthotist's services.

Separate payment records are prepared when a bill is submitted for services rendered in different calendar years in each of which the deductible had been met and payment made.

Separate payment records are also prepared for bills submitted covering specific services requiring special payment procedures designated by Amendments to the Medicare Law. These services include:

1. Hospital-based Radiologist and Pathologists

   Effective October 1, 1982, inpatient radiology and pathology services became payable on the same basis as for other physician services, i.e., 80 percent of the reasonable charge after the Part B deductible has been met.

   Prior to October 1982, Medicare paid these services at 100 percent of reasonable charges with no deductible or coinsurance applied.

2. Diagnostic Laboratory Fees Paid at a Negotiated Rate

   Beginning June 30, 1984, services performed in a laboratory that are billed on an assignment basis may be paid at 100 percent of a negotiated rate with no coinsurance applied; however, payments made are subject to the annual deductible. This applies only to those laboratories which have negotiated a rate agreement with the carrier.

3. Independent Physical Therapists

   Beginning July 1, 1973, services performed by an independent physical therapist in the therapist's office or in the patient's home became covered up to a maximum of $100 a year. This was increased to $500 a year effective January 1, 1982. A separate payment record is prepared for each bill for services performed by an independent therapist until the maximum expense has been incurred.

4. Physician Services Provided to Living Kidney Donors

   Beginning October 1, 1978, physician services provided to living kidney donors are paid at 100 percent. These services include monies for both the kidney donation surgery and the post-operative recovery period. These services are billed to the program under the name and HI Claim Number of the recipient.

5. Used Durable Medical Equipment (DME)

   Beginning November 1, 1977, the purchase of used DME became payable at 100 percent of the reasonable charge less any deductible yet to be met. The used DME charge, however, cannot exceed 75 percent of the cost of new DME.

6. Pneumococcal Vaccine

Effective July 1, 1981, carriers were authorized to pay beneficiaries/physicians 100 percent of the reasonable charge of the cost and administration of pneumococcal vaccine. Both deductible and coinsurance will be waived for this service.

7. Ambulatory Surgical Center

Beginning September 7, 1982, certain services performed in an Ambulatory Surgical Center or in a hospital outpatient setting that are billed on an assignment basis may be paid at 100 percent of the reasonable charge. Payment in this manner is not subject to the deductible or coinsurance.

NOTE: Although separate payment records are prepared for the above types of service, the beneficiary, physician, and calendar year relationship must still exist in all payment records produced.

Whenever payment is made for purchase of durable medical equipment, a payment record is also prepared. If the payments extend over a period of months, a payment record is prepared for each payment even though monthly bills are not submitted.

The 1967 Amendments established, effective January 1, 1968, a separate Part B blood deductible. This deductible is equal to the charge for the first three (3) pints of blood furnished an individual in a calendar year. When a Request for Payment is received for blood charges, no payment record is prepared if those charges represent blood used to satisfy the Part B blood deductible. Charges for blood after the blood deductible has been satisfied and for which payment is made requires the preparation of a payment record.

Deviations are not made from the procedures discussed above for preparing payment records on a "bill" basis. In addition, the format of the payment records and codes to be used for individual fields must conform exactly to those detailed in Exhibit A.

Contents of the Payment Record

For purposes of this manual, a description of payment records used in statistical programs is available in Exhibit A. Carriers code all fields, using the same coding criteria and periodically submit records on magnetic tape. Each record contains beneficiary and physician/supplier identification with reasonable charges and payment amounts. Statistical data includes type and place of service, specialty code of the physician/supplier, and month and year of service.

Approximately 360 million payment records are received annually.

Payment Record Contents

	Information	Description
1.	Health Insurance Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
2.	ZIP Code of residence	Actual
3.	Entry Code	A code for type of payment record being submitted: -Original debit -Supplemental debit -Full credit -Partial credit -Replacement debit -Partial debit
4.	Entry Recode	-Initially submitted, accepted records -Resubmitted accepted records -Initially submitted, rejected records -Resubmitted rejected records -Acknowledge an A reject previously submitted
5.	Beneficiary's Name a. Surname b. First Initial	
6.	Medicare Status Code	Beneficiary's Status: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
7.	Physical Therapy Indicator	-No physical therapy involvement -Physical therapy involvement

Exhibit A

	Information	Description
8.	Receipt Date-HCFA	Julian date of receipt into the EDP system
9.	Original Reason for Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	End Stage Renal Disease Indicator	-No ESRD -MBR -HI -NIH -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH ESRD -Clerical -MBR and clerical -HI and clerical -NIH and clerical -MBR, HI and clerical -MBR, NIH and clerical -HI, NIH and clerical -MBR, HI, NIH and clerical
11.	Carrier Bill Dates a. Date Bill Received	Julian date the bill is received by carrier
	b. Date Bill Paid	Julian date carrier indicates on the payment check. Where the carrier makes payment to physicians on a periodic basis through pre-arrangement, the date paid reflects the date the carrier would have ordinarily prepared the check if the physician were not reimbursed on a periodic basis.
12.	Carrier Number	Unique identification number assigned by HCFA

	Information	Description
13.	Expense Dates	Period for which expense incurred
	First Expense Date	-Indicates year and first Julian day of the month in which expense period began
	Last Expense Date	-Indicates year and first Julian day of the month in which expense period ended
14.	Outpatient Psychiatric	The outpatient Psychiatric Charges expense represents 62 1/2 percent or $312.50 (whichever is less) of the reasonable psychiatric charges for the items on the Request for Payment Form for which payments have been made.
15.	Provider Payment Amount	The amount of payment made to or on behalf of the beneficiary
16.	Carrier Batch Number a. Batch Year	-Unit position of the year in which batch was created
	b. Batch Month	-Month in which the batch was created
	c. Batch Sequence Number	-01-69 Payment batches -70-99 Correction batches
17.	Current Reason for Entitlement	-OASI -DIB -Renal -DIB and Renal
18.	Reasonable Medical Charges (Non-psychiatric)	The reasonable charges for the non-psychiatric items on the Request for Payment form for which payment has been made NOTE: Payment records submitted for payment of services of an independent physical therapist contain a "p" in the high order position of this field

Exhibit A

	Information	Description
19.	Deductible Applied	Amount of incurred expenses in this record which were applied to the deductible. All nines in field indicate 100 percent reimbursement.
20.	Carrier Control Number	Unique control number assigned each payment record by carrier
21.	Control Number Check Character	Assigned by HCFA to ensure unique control for identification of each payment record
22.	Physician or Supplier Identification Code	The number used to identify each individual physician, group, clinic or medical supplier, ambulance service, clinical laboratory, medical supply house, etc. Social Security Account Numbers are to be used for solo-practice physicians and sole-proprietorship suppliers where the request for payment is reimbursed on a fee for service basis. Employer Identification (EI) Number The EI number is to be used when identifying groups, partnerships, or clinics. EI numbers are also used for independent laboratories, group practice prepayment plans, and other entities who bill in a group or company's name, including physicians billing through a provider as hospital-based physicians.

Information	Description
22. Physician or Supplier Identification Code (con.)	Other Identification Numbers Unique identification numbers assigned by the carriers are to be used if the social security or employer identification number is not available. Such usage should be very limited and occur only until valid Social Security or EI numbers can be obtained. NOTE: Vendors providing services outside the U.S. are assigned a unique number. (The provider number as assigned by HCFA or, if none available, a carrier assigned number).
23. Number of Separate Charges	A count of the number of separate covered charges which the carrier has taken into consideration when making the reasonable charge determination. When a series of similar services are represented by an inclusive single charge, each occasion of service is counted as a separate charge. Ninety-nine is used for 99 or more separate charges.
24. Place of Service	Place of service is based on the item with largest single charge on the bill: -Office -Home -Inpatient hospital -SNF -Outpatient hospital -Independent laboratory -Independent Kidney Disease Treatment Center -Ambulatory Surgical Center -Hospice -Nursing Home -Other

Exhibit A

	Information	Description
25.	Type of Service	Type of service is based on the items with the largest single charge on the bill: -Medical care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Whole Blood or Packed Red Cells -Used DME -Ambulatory Surgical Center (Facility Usage) -Hospice -Purchase of DME - Installment Basis -Renal supplies (in the home) -Monthly Capitation Payment (Dialysis) -Kidney Donor -Purchase of DME (Lump Sum) -Rental of DME -Pneumococcal Vaccine -Second Opinion on Elective Surgery -Third Opinion on Elective Surgery The following are definitions of type of service used in assigning the codes listed above: Medical Care - Includes all physician services, including podiatrists and surgical chiropodists not elsewhere classified, and covers office visits, home visits, nursing home visits, and nonsurgical hospital visits. Psychiatric services, diagnostic services, allergy testing, therapeutic procedures, special dermatological procedures, and physical medicine services are included. Consultation is excluded.

Information	Description
25. Type of Service (con.)	Surgery - Includes those procedures recognized in the surgical section of Current Procedural Terminology published by the AMA and covers services pertaining to incision, excision, repair, suture, destruction, introduction, fractures, manipulation, dislocations, amputation, and endoscopy
	Consultation - Refers to the professional service rendered by a physician whose opinion or advice has been requested by another physician or agency for the evaluation and/or treatment of a patient
	Diagnostic X-Ray - X-Ray and related services undertaken for diagnostic purposes. Includes portable X-Ray services.
	Diagnostic Laboratory - Laboratory services, regardless of where rendered, required in the diagnosis of disease or injury. Includes certain mechanical or machine tests such as EKG, EEG, BMT, etc.
	Ultrasound diagnostic procedures are shown under this code.
	Radiation Therapy - Therapeutic services, such as X-Ray, radon, radium, and isotopes for the treatment of malignancies, tumors of bones, brain, or spinal cord, angiomas, vascular nevi, lymphomas leukemia, and thyroid disease
	Anesthesia - Services for anesthesia including the appropriate pre-and post-operative visits, administration of anesthesia, and transfusion of fluids and/or blood incident to the anesthesia or surgery

Exhibit A

Information	Description
25. Type of Service (con.)	Assistance at Surgery - Surgical assistance rendered upon the request of the primary surgeon and governed by the rules for such service prescribed by the carrier Other medical services - Services falling in the following special categories: - Ambulance service - Supplies Whole Blood or Packed Red Blood Cells - Includes bills where the charges are for whole blood or packed red blood cells and where payment is made Used Durable Medical Equipment - Purchase of used DME is payable at 100 percent of the reasonable charge for if such charge does not exceed 75 percent of the cost of new DME (deductible must still be met) Second Opinion on Elective Surgery - Refers to professional services rendered by a physician to a beneficiary who requested a second opinion when surgery is being considered Third Opinion on Elective Surgery - Refers to professional services rendered by a physician to a beneficiary who requested a third opinion when surgery is being considered Monthly Capitation Payment (Dialysis) - Physicians may elect to be paid on a monthly basis for all services rendered to maintenance dialysis patients

	Information	Description
25.	Type of Service (con.)	Kidney Donor - Refers to professional services rendered to a live kidney donor except for the services involving the actual surgical removal of the kidney. Includes: surgery (TOS code 2) anesthesia (TOS 7) assistance at surgery (TOS 8) etc. Show this code where the procedure code does not identify that a living donor is involved e.g., laboratory workup. ASC Facility Usage - Refers to payment to ASCs under provisions made for "facility services," which are services they furnish in connection with a covered surgical procedure which would otherwise be covered if furnished on an inpatient or outpatient basis in a hospital. ASCs may furnish services which are not "facility services". Such services are subject to the usual Part B coverage and payment rules. Renal Supplies (in the Home) - Cost of supplies used in the beneficiary's home in the treatment of end stage renal disease Pneumococcal Vaccine - Refers to 100 percent reimbursement for pneumococcal vaccine and its administration
26.	Type of Physician or Supplier ID Number	-Physician or suppliers billing as solo-practitioners for whom social security numbers are shown in the physician ID code field -Physicians or suppliers billing as solo-practitioners for whom social security numbers are not available and the carrier's own physician ID code is shown

Exhibit A

	Information	Description
26.	Type of Physician or Supplier ID Number (con.)	-Suppliers (other than sole proprietorship) for whom employer identification (EI) numbers are used in coding the ID field -Suppliers (other than sole proprietorship) for whom EI numbers are not known and the carrier's own code has been shown -Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers are used in coding the ID field. Hospitals include HHA & SNF providers. -Hospitals (including hospitals billing for Supplier ID Number hospital-based physicians) and independent laboratories for whom EI numbers are not available and provider numbers assigned by HCFA are shown. Hospitals include HHA & SNF providers. -Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field -Group practice prepayment plans for whom EI numbers are used in coding the ID field -Clinics, groups, associations, partnerships, or GPPP's for whom EI numbers are not available and therefore the carrier's own physician code has been assigned

Information	Description
27. Payment Code	A code indicating whether the payment being recorded was made to the beneficiary to the physician or supplier, to both (partial payment to both the beneficiary and the physician or supplier on the same bill), or a provider where the provider bills for the physician -For payment to physician or supplier -For payment to beneficiary -For partial payment to both -For payment to hospital (hospital-based physicians) -For partial payment to both hospital and beneficiary -For payment to group practice prepayment plan -For payment to all Federally funded entities -For payment to other entities, e.g., employer, union NOTE: a. If a beneficiary is deceased and payment would have been made to him or her alive, payment to beneficiary is indicated

	Information	Description
27.	Payment Code (con.)	b. Payment codes indicating payments to hospitals also include nursing facilities, or home health agencies where payment for the physicians' services are made directly to the facility
28.	Physician or Supplier Speciality Code	A two-digit code for each physician or supplier indicating the physician's major speciality or type of supplier. See Exhibit B. The clinic specialty code (70) should be used only where all of the following conditions are met: (1) The association consists of physicians with mixed (more than one) specialties (2) Charges are uniform for a medical procedure regardless of the individual physician performing the services (3) The request for payment is submitted in the name of the association and not the physician who performs the service An association of two or more physicians may be considered a group (other than clinic) if both (2) and (3) above are met and the physicians involved are all one specialty. The group should be assigned the code applicable to that specialty.

	Information	Description
29.	Region Code	The region of the carrier recording the payment -Boston -New York -Philadelphia -Atlanta -Chicago -Dallas -Kansas City -Denver -San Francisco -Seattle -Railroad Board
30.	Exception Code	Indicates reason for payment record reject: -Record accepted -Name/Number exception -Beneficiary never entitled to Part B -Payment record does not crossfoot -Invalid month of expense -No entitlement in the month of expense -Last month of expense is later than beneficiary month of death (one month tolerance) -Deductible not satisfied -Deductible in payment record exceeds $50 or $60 -Invalid entry code -Blood charges with no previous query containing blood -Radiology/Pathology or Diagnostic Lab testing -Psychiatric monies exceed the maximum -Physical therapy reject -Physical therapy monies exceed the maximum -HMO lockin
31.	State Code of Residence	
32.	County Code of Residence	

Exhibit A

	Information	Description
33.	Date of Birth	Julian date of beneficiary's birth.
34.	Sex	-Male -Female -Unknown
35.	Race	-White -Black -Other -Unknown
36.	Primary Payor	Denotes the primary payor for this bill -Working Aged Beneficiary/Spouse with an Employer Group Health Plan -ESRD Beneficiary in the 12 month coordination period with an Employer Group Health Plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault insurance or any liability insurance -Worker's Compensation -PHS or other federal agency -Disabled beneficiary under age 65 with LGHP -Black Lung -Veterans Administration -Medicare is primary payor

Physician and Supplier Specialty Codes

For each request for payment involving physicians' services, carriers code the specialty of each physician rendering services. The 2 digit codes used are:

Code	Physician Specialization
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease
07	Dermatology
08	Family Practice
09	Gynecology (Osteopaths only)
10	Gastroenterology
11	Internal Medicine
12	Manipulative Therapy (Osteopaths only)
13	Neurology
14	Neurological Surgery
15	Obstetrics (Osteopaths only)
16	OB - Gynecology
17	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths only)
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic Surgery
21	Pathologic Anatomy; Clinical Pathology (Osteopaths only)
22	Pathology
23	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Psychiatry, Neurology (Osteopaths only)

Exhibit B

Physician and Supplier Speciality Codes (con.)

Code	Physician Specilization
28	Proctology
29	Pulmonary Diseases
30	Radiology
31	Roentgenology, Radiology (Osteopaths only)
32	Radiation Therapy (Osteopaths only)
33	Thoracic Surgery
34	Urology
35	Chiropractor, licensed (effective July 1973)
36	Nuclear medicine
37	Pediatrics
38	Geriatrics
39	Nephrology
40	Hand Surgery
41	Optometrist - effective July 1, 1981 (services related to condition of aphakia)
48	Podiatry - Surgical Chiropody
49	Miscellaneous
70	Clinic or other group practice, except GPPP (see note below)
99	Unknown

Individual physicians are considered specialists if they consider themselves specialists and so classify themselves regardless of whether or not they are certified by specialty boards or eligible for certification. For physicians with more than one specialty, the carrier enters the major specialty of the physician on all his or her payment records and does not vary the specialty code with the different types of service reported for that physician.

NOTE: Use of code "70" above. Clinic code "70" is used:

(a) only where charges are uniform for a medical procedure regardless of the individual physician in the group or clinic performing the service; and

(b) only for those groups composed of physicians with mixed (two or more) specialties; and

Physician and Supplier Specialty codes (con.)

(c) only where the request for payment does not identify the performing physician but is submitted in the name of the group.

Groups whose physician members are all one specialty should be assigned the code applicable to that specialty. Specialty code "70" should not be used for such groups.

NOTE: Specialty code use for services in an independent laboratory:

When a physician ordering tests or x-rays submits a request for payment for services performed in an independent laboratory, the physician's specialty code will be shown. If the independent laboratory submits the request, then "type of supplier code 69" is shown.

Coding Type of Supplier--Requests for payment involving services by suppliers other than physicians are coded with a type of supplier code as shown below.

Code	Type of Supplier
51	Medical supply company with CO (Certified orthotist certified by American Board for Certification in Prosthetics and Orthotics) certification
52	Medical supply company with CP (Certified prosthetist certified by American Board for Certification in Prosthetics and Orthotics) certification
53	Medical supply company with CPO (Certified prosthetist-orthotist certified by American Board for Certification in Prosthetics and Orthotics) certification
54	Medical supply company not included in 51, 52, or 53
55	Individual CO
56	Individual CP
57	Individual CPO

Exhibit B

58	Individuals not included in 55, 56, or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public Health or Welfare Agencies (Federal, State and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities, Inc., etc.)
62	Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologists (Billing Independently)
65	Physical Therapist (Independent Practice) (July 1973)
69	Independent Laboratory (Billing Independently)
87	All other e.g., Drug and Department Stores
88	Unknown

Coding Type of Service for Group Practice Prepayment Plans

The following codes are used to code type of service only for bills submitted by group practice prepayment plans on Form HCFA-1556. These codes are used only for services that do not involve a "visit" to a physician. A "visit" to a physician is defined as a formal face-to-face contact between the physician and the patient for purposes of diagnosis or treatment. For bills involving a "visit" to a physician, the specialty of the physician providing services is coded using the physician specialty codes.

Code	Type of Service
71	Diagnostic X-Ray
72	Diagnostic Laboratory
73	Physiotherapy
74	Occupational Therapy
75	Other Medical Care

VII. Part B Medicare Annual Data (BMAD)

Introduction

The data collected in central office prior to May 1984 did not provide all the Part B data necessary to satisfy HCFA's needs. Therefore, additional files were developed to be submitted by carriers annually that would supplement available data. Carriers were required to extract these data from their claims processing history for Medicare claims only.

The BMAD System is based on four separate files.

A. Procedure File - Provides an array of every procedure processed showing the related frequency, submitted charge and paid amount. This gives HCFA detail on the services processed by carriers. The file contains about 8 million records per year. Exhibit A

B. Prevailing Charge/Pricing File - Provides HCFA with prevailing charge limits for each service contained in the Procedure File. This allows HCFA to study and accurately project payment levels. The file contains about 20 million records per year. Exhibit B

C. Provider File - Contains line by line detail from claims history of procedures rendered by a sample of physician/suppliers. This allows HCFA to study the impact of actual and projected program changes on them. It allows HCFA to conduct longitudinal analyses of practice trends. For 1983 and 1984, a one percent sample was required. Starting with 1985, the sample size was increased to five percent of active physicians/suppliers. The file contains about 42 million records per year. Exhibit C

D. Beneficiary File - Contains line by line detail from claims history of services received by all ESRD Beneficiaries and a five percent sample of other beneficiaries. This allows HCFA to link, based upon the Health Insurance Claim Account Number (HICAN), a beneficiary's Part B service utilization data with the Part A service utilization data that exists in other central office files. The file contains about 23 million records per year. Exhibit D

The Office of Statistics and Data Management, HCFA, receives all BMAD Records directly and processes them through a series of edit and validation programs. Files that can not be read or fail critical edits are returned to the carrier for correction. All records passing the initial edits and containing HCFA Common Procedure Coding System (HCPCS) codes are then processed into "Master Files."

For the Procedure, Provider and Beneficiary files, the data are produced and submitted from Medicare claims history for services rendered in the preceding calendar year. The Prevailing Charge/Pricing File, reflects the prevailing charge and fee schedule screens developed in the reasonable charge update. Data are provided in the HCFA specified

formats. Data definitions are consistent with the existing definitions for other HCFA submittals whenever they apply.

BMAD Interactive Systems

The BMAD System consists of basic modules and provides users the capability to access the data files interactively. Only users having an existing user ID/password may access these subsystems directly.

Receipt and Control Subsystem

This module enables the user to obtain timely information on the status of individual carrier's submittals. Additionally carrier totals, by file, are available that provide overall totals of charges, number of records, etc. The Receipt and Control Subsystem is maintained on a calendar year basis.

User Extract Subsystem

The User Extract Subsystem creates four master files, one for each category of data. Information from these master files is extracted and summarized to create user files. The four master files are not directly accessible by the user. Requests for such access should be directed to BDMS/OSDM.

The contents of these user files are determined from the results of an annual user survey. User files are designed to cover the most likely uses of the BMAD data. Each file contains an extract from and/or summary of the BMAD data base. The creation of some of these files requires the use of parameters stored in the classification criteria tables. These user files are expected to meet a large majority of all user requirements from the BMAD System, and hence, assume an important role in the system.

The ability to download data to PCs from the output generated in the user extract system is available to users.

A User Manual describes the methods and procedures available to the BMAD user community for accessing the information contained in these user files. It also includes an overview of the files and an explanation of major data elements.

The following features are found in common throughout the user files:

- Only HCPCS Procedure Codes are extracted.
- Only records which contain no errors in fields of interest are considered for retrieval.

Contents of the BMAD Record

The BMAD record, for each file, is a fixed length record submittal on magnetic tape and contains information associated with the specific file.

Procedure File

This file provides calendar year data on procedure codes. This is an array of every procedure code used by each carrier. The array is in locality, specialty code, type of service, place of service and ascending order of procedure/modifier codes. Every code contained in the preceding calendar year history, even if the code was used only once, is shown.

Exhibit A

Procedure File

	Information	Description
1.	Procedure Code	The 5-digit HCPCS code as recorded in carrier history or converted history
2.	Initial Modifier	The HCPCS 2-digit modifier. If multiple modifiers are reported, the initial modifier is shown.
3.	Specialty	The HCFA 2-digit code showing the type of specialty of the physician/supplier providing the service
4.	Carrier Number	HCFA assigned identification code
5.	Locality	This two digit code identifies the pricing locality used.
6.	Type of Service	This field represents the type of service. -Medical Care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation Therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Whole Blood or Packed Red Cells -Used DME -Ambulatory Surgical Center (Facility Usage) -Hospice -Purchase of DME (Installment basis) -Renal Supplies (in the Home) -Monthly Capitation Payment (Dialysis) -Kidney Donor -Purchase of DME (Lump Sum Payment) -Rental of DME -Pneumococcal Vaccine

	Information	Description
6.	Type of Service (con.)	-Second Opinion on Elective Surgery -Third Opinion on Elective Surgery
7.	Place of Service	This field denotes the place of service. -Office -Home -Inpatient Hospital -SNF -Outpatient Hospital -Independent Laboratory -Other -Independent Kidney Disease Treatment Center -Ambulatory Surgery Center -Hospice -Nursing Home -Other
8.	Second Modifier	If multiple modifiers are used to determine allowed charges, the second modifier is shown.
9.	Region Code	This is a 2 digit code to identify HHS Regions.
10.	Frequency	An unduplicated count of the total number of times that this procedure code/modifier occurred within this locality, specialty, T/S, P/S sequence as reported by or on behalf of, a beneficiary. Duplicates or adjustments to initial line items are not included.

Exhibit A

	Information	Description
11.	Miles/Time/Units Services	The total number of miles (or units) used in calculating allowed charges for covered transportation, or
	(MTUS)	The total number of anesthesia units used in calculating allowed charges for covered anesthesia services, or
		The total number of units (pts.) of blood allowed, or
		The total number of cubic feet (or pounds) of oxygen used in calculating allowed charges for covered oxygen services or the number of services used in calculating allowed charges for allowed physician/supplier services
12.	MTUS Indicator	This field denotes the type of MTUS. -Ambulance Miles -Anesthesia time units -Services -Oxygen units -Blood units -Anesthesia base and time units -No allowed activities
13.	Submitted Charges	Total of submitted charges from all line items for this service included in the Frequency Field rounded to nearest dollar
14.	Allowed Charges	Total of all allowed charges from all accepted line items (including deductible) for this service and then rounded to nearest dollar

	Information	Description
15.	Denied Frequencies	The number of times that the frequency counted in the Frequency field has been denied in full because: claimant ineligible, filing limitations exceeded, services not covered, or services not medically necessary. Duplicates or adjustments are not included.
16.	Amount Denied	Total of the submitted charges from all line items shown in Denied Frequency field and rounded to nearest dollar
17.	Edit Exclusions	The total number of frequencies that represent adjustment actions, duplicate bills or other types of actions that are not included in Frequency field
18.	Amount of Exclusions	The dollar value of the submitted charge for all services in Edit Exclusion field above rounded to nearest dollar
19.	Services Assigned	The number of times the frequency shown in Frequency field was provided on assignment
20.	Initial Modifier Unit	Anesthesia services only. Aggregrated total number of units by the initial modifier.
21.	Second Modifier Unit	Anesthesia services only. Aggregrated total number of units by the second modifier only.
22.	Base Unit	Anesthesia services only. Aggregated base units only.

Exhibit B

Prevailing Charge File

This file provides charge data generated by each carrier for each service during the Reasonable Charge update process.

	Information	Description
1.	Procedure Code	The 5-digit HCPCS code for every service recorded on this file
2.	Initial Modifier	The HCPCS 2-digit modifier that results in a separate prevailing charge. If multiple modifiers are reported, the initial modifier is shown.
3.	Specialty Indicator	Code to indicate if Pricing Specialty is same as HCFA
4.	Carrier Number	HCFA assigned identification code
5.	Locality	This two digit code identifies the pricing locality used.
6.	Pricing Type of Service Indicator	Code to indicate if pricing type of service is same as HCFA
7.	Second Modifier	If multiple modifiers are used to determine prevailing charges, the second modifier is shown.
8.	Pricing Type of Service	Type of service code used for profile development
9.	Pricing Specialty	Specialty code used for profile development
10.	Region Code	This is a 2 digit code to identify HHS Regions.
11.	Relative Value Scale	-Relative Value Unit (RVS), or -Relativity not Established (RNE), or -By Report, where individual consideration is used to price the service.

	Information	Description
12.	Conversion Factor	The Prevailing Charge conversion factor (CF) that is appropriate for this service
13.	50%	The 50% percentile value calculated for this service
14.	75%	The unadjusted prevailing charge for this locality and specialty that was calculated for this service
15.	Origin	The origin of the data used to calculate the 75th percentile unadjusted prevailing charge -75th percentile "N/A" -Medicare data only -Private business and Medicare -Other data -Private business only -Medicaid only -Medicare and Medicaid -Medicare, Medicaid, and private business
16.	Gap Fill Prevailing Charge	Coded only if unadjusted prevailing charge (75%) does not contain a calculation, the gap-fill unadjusted prevailing charge which will be used in the claims processing sequence. Where insufficient data exists to calculate a value, "RVS" is shown.
17.	Source of Prevailing Charge	Coded to indicate source: -Locality by specialty -Carrier wide/by specialty -Locality/no specialty -Carrier wide/no specialty -Array of actual charges -Other calculated value -"RVS" shown in Gap Fill Prevailing charge to reflect that insufficient data are available to calculate a value. -Unknown

Exhibit B

	Information	Description
18.	Adjusted 75% (Prevailing Charge) (Participating Physicians and Suppliers)	The numeric value of the prevailing prevailing charge that will be used for payment determination, i.e., the actual unadjusted prevailing charge, the Economic Index (EI) adjusted prevailing charge or another screen value, whichever is less
19.	Source of Adjustment (Participating Physicians and Suppliers)	The source of the value shown in adjusted 75 percent participating physicians -No charge adjustment was made to the prevailing charge or no prevailing charge value was calculated. -EI adjustment -Lowest charge adjustment -No roll back adjustment -Price list -Inherent reasonableness -Other -Comparability
20.	MAPC	Maximum Allowed Prevailing Charge
21.	Medicare Frequency	Total number of times that this procedure code/modifier, locality, pricing specialty, pricing type of service was used in developing the Prevailing Charge
22.	Medicare Frequency Indicator	-Medicare services only used to develop prevailing charge -Both Medicare and non-Medicare service counted in Medicare frequency
23.	Generated Indicator	BMAD internal use only
24.	Fee Schedule	Fee schedule amount for clinical lab, radiology, and DME services subject to the fee schedule

	Information	Description
25.	Fee Schedule Indicator	-Inexpensive/routine purchase -Frequent/substantial service -Customized Items -Prosthetics and Orthotic Devices -Capped Rental Items -Oxygen and Oxygen Equipment -Fee Schedule - Radiology -Fee Schedule - Clinical Lab -Nonfee Schedule for DME, -Radiology or Clinical Lab

Exhibit C

Provider File

This file provides data for all services rendered by selected physicians/suppliers. Prior to the 1985 submittals the sample size was a one percent sample of all active physician/suppliers in a carrier's service area. For 1985 and later, the sample size was increased to five percent of those active in the calendar period, i.e., January through December. The sampling techniques used by carriers and specified by HCFA and all physicians/suppliers initially selected must be retained and reselected in subsequent years if they are currently active.

	Information	Description
1.	Provider ID Number	The carrier assigned number is shown. Services of solo practicing physician/suppliers with more than one identifying number are combined. Group practices should show only services by the group provider ID.
2.	Procedure Code/Initial Modifier	The 5-digit HCPCS procedure code. The initial HCPCS 2-digit modifier.
3.	Specialty	The two digit HCFA code of the physician/supplier providing the service
4.	Type of Service	HCFA Type of Service. Coded same as Type of Service field of Procedure File.
5.	Place of Service	HCFA Place of Service. Coded same as Place of Service field of Procedure File.
6.	First Expense Date	Julian date of first expense date
7.	Carrier Control Number	Control number assigned to each claim
8.	Health Insurance Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
9.	Carrier Number	HCFA assigned identification number
10.	Locality	This is the two digit code used to identify the pricing locality used.

	Information	Description
11.	Type of Provider	-Physicians -Institutional Providers -Independent Lab -Clinics -Groups -Other Entities -Suppliers
12.	Region Code	HCFA region codes
13.	Submitted Charge	Dollars and cents
14.	Allowed Charge	Dollars and cents
15.	Processing Indicator	Coded as follows: -Allowed -Both allowed and denied where a from-to service contains services that were denied -Denied -Reprocessed - adjustments based upon subsequent reprocessing of the claim -Other -Secondary Payor -MSP - Conditional Payment
16.	Assignment Indicator	Coded as follows: -Participating Provider -All or some covered and allowed expenses applied to deductible- participating provider -Assignment accepted - nonparticipating provider -Assignment not accepted - nonparticipating provider -Assignment accepted but all or some covered and allowed expenses applied to deductible- nonparticipating provider -Assignment not accepted and all or some covered and allowed expenses applied to deductible- non-participating provider

Exhibit C

	Information	Description
17.	Reimbursement	Dollars and cents
18.	Reimbursement Indicator	Indicates whether the amount shown in Reimbursement field represents service or claim
19.	Date Paid	Julian date shown on benefit check or the EOMB
20.	Last Expense Date	Julian date of last expense date
21.	MTUS	Miles/Time/Units/ or number of services
22.	MTUS Indicator	Coded same as MTUS indicator field of Procedure File
23.	Payment Indicator	Coded to indicate which payment screen was used to determine the payment -Non-payment -Actual Charge -Customary Charge -Prevailing Charge (adjusted, unadjusted, gap fill, etc.) -Other (including ASC facility fees, radiology and outpatient limits) -Lab Fee Schedule
24.	ESRD Indicator	Coded to identify beneficiary -ESRD Beneficiary -Not ESRD Beneficiary
25.	Number of Physician/Suppliers	The number of Physicians or Suppliers reporting under this number at the end of the calendar year.
26.	ZIP Code	5 digit zip code of Physician/Supplier ID Number
27.	Old BIC Code	Original BIC sent by carrier

	Information	Description
28.	Physician/Supplier Indicator	-Physician/Supplier ID represents same Physician/Supplier, regardless of multiple locators -Physician/Supplier ID represents one of multiple numbers used for same Physician/Supplier
29.	Pricing TOS	Type of service code used for profile development
30.	Second Modifier	Second modifier if multiple modifiers are used to determine allowed charges
31.	Initial Modifier Unit	Anesthesia services only. Aggregated number of units represented by the initial modifier.
32.	Second Modifier Unit	Anesthesia services only. Aggregated number of units represented by the second modifier.
33.	Base Unit	Anesthesia services only. Aggregated base units allowed.
34.	Pricing Specialty Code	Specialty code used for profile development

Exhibit D

Beneficiary File

This file contains a five percent sample of all beneficiaries in the carrier's history file. Sample is based on terminal digits of the HI claim number. All services rendered to the selected beneficiaries are included in this file. Line item detail is also received for all ESRD beneficiaries.

	Information	Description
1.	Health Insurance Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alpha-numeric suffix (BIC) identifies the claimant.
2.	Carrier Number	HCFA assigned identification number
3.	Carrier Control Number	Control number assigned to each claim
4.	Old BIC Code	Original BIC sent by carrier
5.	Region Code	HCFA Region Code
6.	Multi-Record Indicator	-Multiple records -Single records
7.	NBR Line Item	-Number of line items contained in the record
8.	Procedure Code/Initial Modifier	The 5-digit HCPCS procedure code. The HCPCS 2-DIGIT Modifier.
9.	Type of Service	Coded same as Type of Service field of Procedure File
10.	Specialty Code	The 2-digit HCFA code of the physician/supplier providing the service.
11.	Provider ID Number	The carrier assigned number as shown. All services of solo-practicing physicians/ suppliers who have been assigned more than one identifying number are combined. For group practice providers, only those services performed by that group provider ID are shown.

	Information	Description
12.	Type of Provider	Same as for Type of Provider field of Provider File
13.	Submitted Charge	Dollars and cents
14.	Allowed Charge	Dollars and cents
15.	Reimbursement Amount	Dollars and cents
16.	Reimbursement Indicator	Indicates whether the amount shown in Reimbursement Amount field represents service or claim
17.	Place of Service	Coded same as Place of Service field of Procedure File
18.	Date Paid	Julian date shown on benefit check or the EOMB
19.	First Expense	Julian date of first expense date of Date service
20.	Last Expense	Julian date of last expense date of Date service
21.	MTUS	Miles/Time/Units/ or number of services
22.	MTUS Indicator	Coded same as MTUS Indicator field Procedure File
23.	Assignment Indicator	Coded as follows: -Participating Provider -All covered and allowed expenses applied to deductible - participating provider -Assignment accepted - nonparticipating provider -Assignment not accepted nonparticipating provider

Exhibit D

	Information	Description
23.	Assignment Indicator(con.)	-Assignment not accepted but all covered and allowed expenses applied to deductible - nonparticipating provider -Assignment not accepted and all covered and allowed expenses applied to deductible - nonparticipating provider
24.	Processing Indicator	Coded as follows: -Allowed -Both allowed and denied where a from-to service contains services that were denied -Denied -Reprocessed - adjustments based upon subsequent reprocessing of the claim -Other -Secondary Payor
25.	Payment Indicator	Coded to indicate which payment screen was used to determine the payment -Non-payment -Actual Charge -Customary Charge -Prevailing Charge (adjusted, unajusted, gap fill, etc.) -Other (including ASC facility fees, radiology and outpatient limits and non-payment because of denial) -Lab Fee Schedule
26.	ESRD Indicator	Coded to identify beneficiary -ESRD Beneficiary -Not ESRD Beneficiary
27.	Beneficiary Sex Code	Coded as follows: -Male -Female -Unknown
28.	Locality	This 2-digit code is used to identify the pricing locality.

	Information	Description
29.	Pricing Specialty	-Specialty used for profile development
30.	Physician/Supplier Indicator	-Physician/Supplier ID represents same Physician/Supplier, regardless of multiple locators -Physician/Suppliers ID represents one of multiple numbers used for same Physician/Supplier
31.	Pricing TOS	Type of Service code used for profile development
32.	Second Modifier	Second modifier if multiple modifiers are used to determine allowed charges
33.	Initial Modifier Unit	Anesthesia services only. Aggregated number of units represented by the initial modifier.
34.	Second Modifier Unit	Anesthesia services only. Aggregated number of units represented by the second modifier.
35.	Base Unit	Anesthesia services only. Aggregated base units allowed.

VIII. Special Purpose Files

Introduction

This chapter describes several special purpose files which are created from the detailed billing records and are used to prepare payment rates, publication tabulations and analytical research notes.

Health Insurance Bill Skeleton File for State and County Reimbursement File (Exhibit A)

This file is used to create an annual file: Reimbursement by State and County. This is an annual Medicare publication with payment amounts based on the year claims are approved for payment by intermediaries or carriers. PPS inpatient hospital pass-thru amounts are included in the intermediary payments. The file is also used in the adjusted average per capita cost (AAPCC) calculations used to determine payments to risk HMO's.

The file is created by extracting information from each detailed billing and payment record processed by HCFA. The write-off occurs weekly.

Approximately 193,000,000 records are involved annually.

Person Summary File (Exhibit B)

The Person Summary file used to create the annual Medicare Utilization Publication is based on persons receiving paid services in a given calendar year. The file is created from all bills with a date of service in the file year and with amounts paid greater than zero. Data for aged persons are based on a five percent sample of beneficiaries, and for disabled persons are based on a 25 percent sample. These two files are summarized separately, each month, by person, to bring together all paid services for each person during the year.

Approximately 1,000,000 aged and 600,000 disabled records are created annually.

Outpatient Bill Skeleton File (Exhibit C)

This file is prepared annually for a 5 percent sample of bills for outpatient hospital services. For each service year, the file is prepared from all bills processed by HCFA through the period ending 12 months after the end of the service year. For example, the 1988 file is prepared from all outpatient bills processed through December 1989 having a date of service in 1988.

Approximately 2,100,000 records are involved annually.

Home Health Agency Skeleton File (Exhibit D)

This file is prepared annually for a 40 percent sample of bills for Home Health Agency services. For each service year, the file is prepared from all bills processed by HCFA through the period ending 12 months after the end of the service year. For example, the 1988 file is prepared from all HHA bills processed through December 1989 having a date of service in 1988.

Approximately 2,000,000 records are involved annually.

Health Insurance Bill Skeleton File
For State And County Reimbursement File

	Information	Description
1.	Record Identification Code	-Part B Payment Record -Part A Bill -Part B Bill other than Payment Record
2.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric portion (BIC) identifies the claimant.
3.	State Code of Residence	SSA Standard State code
4.	County Code of Residence	SSA Standard county code
5.	Date of Birth	Year and Julian date of beneficiary's birth
6.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
7.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
8.	Format-Payment Record/Form Other than Payment Record	Source of Information For Payment Records: -New Format -Old Format For other than Payment Records: -Inpatient -Outpatient -Christian Science -Home Health -Nonpayment Bills

Exhibit A

	Information	Description
9.	Entry Code-Payment Record/Query Code Other than Payment Record	A code for type payment record being submitted: -Original debit -Supplemental -Full credit -Partial credit -Replacement debit -Partial debit -Correction record acknowledges full overpayment; also acknowledges an A reject previously submitted. -Correction record acknowledges partial overpayment. Code indicating status of bill other than payment records: -Interim Bill -Visits Exhausted (HHA) -Final Bill -Discharge Notice (Non-covered Bill) -Debit Adjustment -Credit Adjustment
10.	Recode Code (Payment Record)/Transaction Code (Other than Payment Record)	Code indicating that a payment record is an initial submittal, a resubmittal, an initial reject, or a resubmitted reject: -Initially submitted, accepted records -Resubmitted accepted records -Initially submitted, rejected records -Resubmitted rejected records Codes for records other than payment record indicating type of facility: -Christian Science SNF -Psychiatric Hospital Facility -Tuberculosis Hospital Facility -General Care Hospital Facility -Regular SNF -HHA -Outpatient

	Information	Description
11.	Date Paid (Payment Record)/Date Approved (Other than Payment Record)	Julian date
12.	Provider Payment Amount	
13.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
14.	Current Reason for HI Entitlement	-OASI -DIB -Renal
15.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
16.	ESRD-DIB Data Indicator	-All Off -ESRD Spouse or Child of Worker -Prior Unqualifying DIB -Both Conditions Present
17.	ZIP Code of Residence	Actual
18.	Date of Service	Julian date service incurred
19.	Place of Service	(Payment Records only - blank filled for Bills) -Office -Home -Inpatient Hospital -SNF -Outpatient Hospital -Independent Laboratory

Exhibit A

	Information	Description
19.	Place of Service (con.)	-Independent Kidney Disease Treatment Center -Ambulatory Surgical Center -Hospice -Nursing Home -Other
20.	Type of Service	(Payment Records only - blank filled for Bills) -Medical Care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation Therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Whole blood or Packed Red Cells -Used DME -Ambulatory Surgical Center (Facility Usage) -Hospice -Purchase of DME-Installment Basis Renal supplies (in the home) -Monthly Capitation Payment (Dialysis) -Kidney Donor -Purchase of DME (Lump Sum) -Rental of DME -Pneumococcal Vaccine -Second Opinion on Elective Surgery -Third Opinion on Elective Surgery
21.	Carrier Number (Payment Records) Provider Number (Other than Payment Records)	For Payment Records, Carrier Number. For bills other than Payment Records, Provider Number shown on Bill.
22.	Total Charges	Total Charges. For Payment Records, this field is the sum of Medical Charges plus Psychiatric Charges.

	Information	Description
23.	Total HHA Visit Charges	HA bills only. Zero filled for other Bill types and Payment Records. Total charges for HHA visits.
24.	Total Inpatient Days of care/Total HHA Visits	Inpatient, SNF, HHA, and Non-Covered Inpatient Bills only. Zero filled for Outpatient and Non-covered HHA Bills and Payment Records. Inpatient Hospital Days of Care/Home Health Agency Visits.
25.	Inpatient Covered Days	Inpatient, SNF, and Non-Covered Inpatient Bills only. Zero filled for other Bill types and for Payment Records. Number of covered days.
26.	HHA Plan Code	HHA Bills only. Blank filled for other Bill types and Payment Records, except for Non-covered HHA Bills which are force coded 'P'. Type of Bill -Part A -Part B
27.	Service From Date	Bills only. Zero filled for Payment Records. Julian beginning date of stay or service.
28.	Patient Status	Inpatient, SNF, HHA, and Non-covered Bills only. Blank filled for Outpatient Bills and Payment Records. -Discharged -Died -Still Patient -Visits Exhausted
29.	Specialty Code	Payment Records only. Blank filled for Bills. Physician or Supplier Specialty Code.

Exhibit A

	Information	Description
30.	Date of Admission	Julian date of admission. Inpatient and SNF Bills only. Zero filled for other bill types and Payment Records.
31.	Length-of-Stay	Number of days from date of admission through date of service. Not computed for Interim Bills. Inpatient and SNF Bills only. Zero filled for other bill types and Payment Records.

Person Summary File

	Information	Description
1.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
2.	State Code	SSA Standard State code obtained from Master Record indicating State of beneficiary's residence
3.	County Code	SSA Standard county code obtained from Master Record indicating county of beneficiary's residence
4.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
5.	Date of Birth	Beneficiary's date of birth
6.	Date of Death	Beneficiary's date of death
7.	Race	-White -Non-White -Unknown
8.	Sex	-Male -Female
9.	Age	Age at last birthday as of 07/01/YY if alive at end of year. For aged age 64, consider as age 65. For disabled age 65, consider as age 64. For persons who died, use age as of date of death.
10.	Patient Status	-Discharged (alive) -Died -Still patient

Exhibit B

	Information	Description
11.	Number of Inpatient Stays	
Provider Payment Amounts (Dollars and Cents)		
12.	Inpatient Hospital	
13.	Skilled Nursing Facility	
14.	HHA Part A	
15.	Physician and Other Medical Services	
16.	Outpatient	
17.	HHA Part B	
18.	Total Part A	
19.	Total Part B	
20.	Total Part A and/or Part B	
21.	Part A and Part B	
22.	Part A only	
23.	Part B only	

Outpatient Bill Skeleton Record - 5% Sample

	Information	Description
1.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
2.	Date of Birth	Julian date of beneficiary's birth
3.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
4.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
5.	State Code	SSA Standard State code obtained from Master Record indicating State of beneficiary's residence
6.	County Code	SSA Standard county code obtained from Master Record indicating county of residence
7.	ZIP Code of Residence	Actual
8.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9.	Provider Number	Identification number of the provider submitting the claim
10.	Type of Service	-Inpatient -Outpatient -Other

Exhibit C

	Information	Description
11.	Diagnosis Code (Field is repeated five times)	Diagnostic code assigned from ICD-9-CM, Volumes I and II
12.	Surgical Procedure Code (Field is repeated three times)	Code assigned from ICD-9-CM, Volume III
13.	Number of Clinic Visits	Actual Number
14.	Number of Emergency Room Visits	Actual Number
15.	Covered Charges	Covered charges for each service: -Clinic Visits -Emergency Room -Laboratory -Radiology -Pharmacy -Blood -Ambulance -Physical Therapy -ESRD -Other
16.	Total Covered Charges	Total covered charges for above services
17.	Date of Last Service	Year and Julian date of last service
18.	Provider Payment Amount	An interim payment made to the institution. Final payment is made based on a cost report each institution is required to prepare at the end of their fiscal year.
19.	Surgery Indicator	Indicates if surgery was performed
20.	Unibill Indicator	Indicates if Unibill or Patbill
21.	Number of Revenue Center Codes	Number of Unibill Revenue Center Codes for services

	Information	Description
22.	Revenue Center Information	
	a. Codes	Identifies specific revenue center
	b. Units	Number of times the revenue center was accessed
	c. Charges	Charges for each revenue center code
23.	Bill Value	Based on Query code -1 Credit Adjustment +1 Debit Adjustment

Exhibit D

Home Health Agency Skeleton Record - 40% Sample

	Information	Description
1.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
2.	Date of Birth	Year and Julian date of beneficiary's birth
3.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
4.	Race	Race code from HI Master Record: -White -Black -Unknown
5.	State Code	SSA Standard State code obtained from HI Master Record indicating State of beneficiary's residence
6.	County Code	SSA Standard county code obtained from HI Master Record indicating county of beneficiary's residence
7.	ZIP Code of Residence	Actual
8.	Medicare Status Code	-Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
9.	Provider Number	Identification number of the provider submitting the claim
10.	Record Identification Code	-Part A -Part B

	Information	Description
11.	Diagnostic Code	Code assigned from ICD-9-CM, Volumes I and II
12.	Number of Diagnoses	
13.	Period From Date	Julian from date of billing period
14.	Period Through Date	Julian through date of billing period
15.	Status Code	-Discharged alive -Died -Still Receiving Services
16.	Visits and Charges A. Skilled Nursing Care B. Physical Therapy C. Speech Therapy D. Occupational Therapy E. Medical Social Services F. Home Health Aide G. Other Visits (1) Other Visits (2)	For each category: -Number of Visits -Dollars and Cents
17.	Total Visits	Total visits for all services
18.	Total Visit Charges	Total charges for HHA visits
19.	Other Charges	Total other charges
20.	Total Charges	Total charges including other charges
21.	Provider Payment Amount	An interim payment made to the institution. Final payment is made based on a cost report each institution is required to prepare at the end of their fiscal year.
22.	Query Code	
23.	Unibill Indicator	Indicates whether Unibill or Patbill
24.	Original BIC	Beneficiary Identification code as submitted on bill

IX. Continuous Medicare History Sample File

Introduction

The Medicare System provides for processing and maintenance of all utilization health insurance bills, payment records, and enrollment records. As a by-product of this system, individual HCFA statistical files are obtained to provide data bases for all types of information about the Medicare program. Until the implementation of the Continuous Medicare History Sample (CMHS), all requests for person data over a time period of more than a single year had to be processed by combining various individual files. A more efficient method of obtaining hospital and medical insurance data is to create a sample file consisting of selected fields from the various Medicare bill files on an ongoing scheduled basis. Such a file permits more in-depth studies of utilization patterns over extended time periods.

The CMHS file is intended to provide more efficient access to person data on a longitudinal basis. This file, being a combined file and having annual updates, has eliminated the problem of having to refer to old files with old formats. Information for all years (representing services after 1973) are consistent and fully documented and contained in this one file.

Preparation of CMHS

The CMHS file is prepared on a 5 percent sample person basis for years 1974 and later and provides a combined record of all Medicare activity for each year. Selection of beneficiaries to be included in this file is based on the ever-enrolled (1974 and later) concept. Thus, beneficiaries enrolled in the Medicare program after 1973, regardless of utilization activity, are represented in this file. Selected personal characteristics are obtained from both the active and inactive HISKEW files. Utilization data for each year are selected from inpatient hospital, skilled nursing facility, home health agency, and outpatient bills that are processed by Medicare intermediaries, and physicians. Service information is obtained from payment records that are processed by Medicare carriers.

Each portion obtained is then combined to form one record for each Medicare beneficiary within the sample on an ongoing basis. Once a beneficiary is included in the CMHS sample that person remains on the file regardless of activity or death. This provides the flexibility for ready access of person data needed to follow utilization patterns of each sample beneficiary.

The initial selection of beneficiaries included in this sample file was based on records obtained from the active and inactive HI Master Enrollment Record as of the update closest to April 1, 1975, with the following characteristics:

1. Primary and/or cross-reference HI claim number in the 5 percent sample.

2. Current entitlement to hospital insurance benefits (Part A) and/or supplementary medical insurance benefits (Part B) was before January 1, 1975, without current termination before January 1, 1974, i.e., anyone ever enrolled in 1974.

Subsequent updates of additional beneficiaries will continue to be based on entitlement after 1973 and will be obtained annually from the updated Master Enrollment File. In addition to newly entitled beneficiaries, those previously included are reselected from the enrollment file from subsequent years for use in a current update. This provides the CMHS file with current demographic characteristics. An annual segment is appended to the Master Record portion of all active beneficiaries and provides the means for noting changes in benefit status, residency, and type of enrollment. The status and coverage characteristics are based as of July 1 of the reference year.

All sample utilization records (bills and payment records) included in the initial preparation of the CMHS were selected from records processed through June 1975 with services in 1974.

Subsequent annual updates to the CMHS included those initial debit utilization records with service dates after December 31, 1973, processed since the prior years' file through the June update of the current year. Thus, when accreting for 1980 activity, only sample records with service dates of 1974-1980 and processed through June 1981 are used. The types of utilization records used to obtain information are as follows:

1. MEDPAR Stay Records

   a. Inpatient hospital stay records representing complete stays are summarized by year of discharge. The discharge date, status and diagnostic related group (DRG) of the last short-stay hospitalization is retained with the summary information on short-stay hospital utilization.

   b. Skilled nursing facility (SNF) stay records representing complete and incomplete stays are summarized by year of admission. The incomplete SNF stays are replaced in subsequent updates when a complete record with a discharge date has been processed.

2. Home Health Agency (HHA) Bill Skeleton Records.

   These records contain information on visits and services delivered by HHA providers and are summarized by year based on through-date of service.

3. Outpatient Hospital Bill Records

   These records represent bills for visits to and services provided in hospital emergency rooms and outpatient clinics. The utilization is summarized by year of the last service date for each type of service.

4. Part B Payment Records

   These records represent payments for services delivered by non-institutional providers such as physicians, suppliers, laboratories, etc. Several types of utilization determined by specialty code and place of service are summarized by year using the last expense date.

5. Group Health Plan (GHP) Master Enrollment

   The GHP master file is used to identify CMHS beneficiaries with any GHP enrollment.

Contents of the CMHS Record

The complete CMHS record varies in size, based on whether Medicare utilization is present or not, type of service utilized by the beneficiary and the number of years involved. Approximately 1.3 million records were initially established in 1974 and subsequent year updates have added an estimated 100,000 records annually. The file is maintained in beneficiary sequence and contains the following sections:

1. Fixed Portion: This portion is present for every beneficiary on the CMHS and is comprised of the following groups:

   a. enrollment group: contains personal characteristics of the beneficiary such as date of birth, sex, race, entitlement dates, date of death and current update information.

   b. years present: contains an indicator of eligibility for each year maintained on the CMHS.

   c. trailer counts: contains the number of occurrances of each section of variable data.

2. Annual Data: Present for every year of eligibility and contains demographic data, indicator of utilization, total reimbursement, and yearly indicators.

3. Demographic Data: Provides the means for noting change in benefit status, residency, and type of enrollment.

4. HHA Trailer: Contains utilization (visits, charges, reimbursement) for an estimated 75,000 beneficiaries per year.

5. Outpatient Trailer: Contains utilization (bills, charges, reimbursement) for an estimated 500,000 beneficiaries per year.

6. Payment Trailer: Contains utilization (records, reasonable charges, reimbursement) for an estimated million beneficiaries per year.

7. Inpatient Trailer: Contains utilization (stays, days, charges, reimbursement) for an estimated 350,000 beneficiaries per year.

8. SNF Trailer: Contains utilization (stays, days, charges, reimbursement) for an estimated 14,000 beneficiaries per year.

9. GHP Trailer: This section provides information (plan-number, status, dates) for each GHP membership period.

Note: Exhibit A details the record description of each field possible for a CMHS beneficiary. Due to various process changes certain items may only be available since the system redesign (effective with 1982 data).

Fixed Portion

	Information	Description
1.	Record Size	-Length of Record
2.	Record Type	-Accreted in or after 1982 -No eligible update after 1981 -Updated after 1981
3.	HCFA Claim Number	The 9 digit Social Security Number of the primary beneficiary
4.	Beneficiary Identification Code (BIC)	-Equated BIC identifying the claimant's relationship to the primary beneficiary
5.	First Update	-First Year Julian date
6.	Last Update	-Last Year Julian date
7.	Last Stay Data	-Information from last short-stay hospitalization Note: Not available if no eligible update after 1981.
	a. Discharge Date b. DRG c. Discharge Status	-Julian date -DRG Code -Alive -Dead -Still a patient
8.	Date of Birth	-Julian date
9.	Sex	-Unknown -Male -Female
10.	Race	-Unknown -White -Black -Other

Exhibit A

Fixed Portion

	Information	Description
11.	Latest Part A Entitlement	Julian date
12.	Latest Part A Termination	Julian date
13.	Prior Part A Entitlement	Julian date
14.	Prior Part A Termination	Julian date
15.	Reason For Latest Part A Termination	-No Termination -Death -Non-Payment of Premium -Voluntary Withdrawal -Entitled Under Another Number -Cessation of Disability -Other
16.	Latest Part B Entitlement	Julian date
17.	Latest Part B Termination	Julian date
18.	Prior Part B Entitlement	Julian date
19.	Prior Part B Termination	Julian date
20.	Reason For Latest Part B Termination	-Same as Part A
21.	Date of Death	Julian date
22.	Original Reason for Entitlement (OREC)	-Original Reason for Entitlement -OASI -DIB -Renal -DIB & Renal
23.	Original BIC	-Original BIC Code
24.	Lifetime Reserve Days	-Lifetime Reserve Days Remaining

Fixed Portion

	Information	Description
25.	Lifetime Psychiatric Days	-Lifetime Psychiatric Days Remaining
26.	Years Present	-Each field contains 1 of 15 possible years of eligibility (1974-1989) -Eligible for year -Not eligible for year

Exhibit A

Trailer Counts

	Information	Description
1.	Number of Annual Trailers	-Number of annual trailers
2.	Number of Demographic Trailers	-Number of unique demographic trailers
3.	Number of Home Health Agency (HHA) Trailers	-Number of HHA Trailers
4.	Number of Outpatient (OP) Trailers	-Number of OP Trailers
5.	Number of Payment Record Trailers	-Number of Payment Record Trailers
6.	Number of Inpatient Trailers Trailers	-Number of Inpatient
7.	Number of Skilled Nursing Facility (SNF) Trailers	-Number of SNF Trailers
8.	Number of Group Health Plan (GHP) Periods	-Number of GHP Membership Periods Note: Does not represent years for GHP

Annual Data

	Information	Description
1.	Utilization Key	-Value Space
2.	Utilization Year	-YY (E.G. 74)
3.	Demographic Trailer Location	-Actual location of demographic trailer for the utilization year
4.	Utilization Indicator	-Indicates whether or not a utilization year trailer is present for each of the types of service
	a. Home Health Agency Indicator b. Outpatient Indicator c. Payment Record Indicator d. Inpatient Indicator e. Skilled Nursing Facility Indicator	
5.	Part A Payment	-Total Part A Payment
6.	Part B Payment	-Total Part B Payment
7.	Part B Medical Expense	-Total Part B Medical Expenses from Part B query
8.	GHP-Indicator	Group Health Plan Enrollment -None -HMO -HCPPP -HMO & HCPPP -GPPP -HMO & GPPP -GPPP & HCPPP -HMO & HCPPP & GPPP
9.	Part A Third Party	-No Third Party Involvement -State Buyin -Reserved -Civil Service -Third Party
10.	Part B Third Party	-Same as field 9

Exhibit A

Demographic Data

	Information	Description
1.	Type	-Value '*'
2.	Year	-First year of unique data
3.	Current Reason for Entitlement Code	Current reason for entitlement -OASI -DIB -Renal -DIB & Renal
4.	Medicare Coverage Code	-Medicare Coverage Code -None -Part A Only -Part B Only -Part A & Part B
5.	Medicare Status Code	Medicare Status Code -Aged without ESRD -Aged with ESRD -DIB without ESRD -DIB With ESRD -ESRD Only
6.	End Stage Renal Disease Indicator	Notice of ESRD -No ESRD -ESRD
7.	State of Residence	-SSA Standard State Code
8.	County of Residence	-SSA Standard County Code
9.	ZIP Code of Residence	-ZIP code

Home Health Agency Trailer

	Information	Description
1.	Type	-Value 'A'
2.	Year	-Reference Year -Obtained from 'Through Date'
3.	Part A Totals	
	a. Visits	-Number of Part A Visits
	b. Charges	-Total Part A charges
	c. Other Charges	-Total Part A other charges
	d. Payment	-Total Part A Payment
4.	Part B Totals	
	a. Visits	-Number of Part B Visits
	b. Charges	-Total Part B Charges
	c. Other Charges	-Total Part B Other Charges
	d. Payment	-Total Part B Payment

Exhibit A

Outpatient Trailer

	Information	Description
1.	Type	-Value 'B'
2.	Year	-Reference Year Obtained from 'Last Service Date'
3.	Services	-Type of Service Outpatient
	a. Bills	-Number of Bills
	b. Covered Charges	-Dollars
	c. Payment	-Dollars
4.	Outpatient Inpatient Services	-Type of Service Inpatient
	a. Bills	-Number of Bills
	b. Covered Charges	-Dollars
	c. Payment	-Dollars
5.	Outpatient Other Services	-Type of Service Other
	a. Bills	-Number of Bills
	b. Covered Charges	-Dollars
	c. Payment	-Dollars

Payment Record Trailer

	Information	Description
1.	Type	-Value 'C'
2.	Year	-Reference Year Obtained from 'Last Expense' Field
3.	All Services	-Total Hospital and Non-Hospital
	a. All Records	-Total Records
	b. All Reasonable Charges	-Dollars
	c. All Payments	-Dollars
4.	Physician Services	-Total Physicians Services
	a. Physician Records	-Total Physicians Records
	b. Physician Reasonable Charges	-Dollars
	c. Physician Payment	-Dollars
5.	Surgical Services	-Total Surgical Services
	a. Surgical Records	-Total Surgical Records
	b. Surgical Reasonable Charges	-Dollars
	c. Surgical Payment	-Dollars
6.	Supplier Services	-Total Supplier Services
	a. Supplier Records	-Total Supplier Records
	b. Supplier Reasonable Charges	-Dollars
	c. Supplier Payment	-Dollars
7.	Hospital Services	-Total Hospital Services
	a. Hospital Records	-Total Hospital Records
	b. Hospital Reasonable Charges	-Dollars
	c. Hospital Payment	-Dollars
8.	Psychiatric Charges	-Total Psychiatric Charges
9.	Unassigned Totals	-Total unassigned Totals
	a. Unassigned Records	-Total unassigned Records
	b. Unassigned Payment	-Dollars

Exhibit A

Inpatient Trailer

	Information	Description
1.	Type	-Value 'D'
2.	Year	-Reference year obtained from 'Discharge Date' field
3.	Totals	-Inpatient Totals
	a. Stays	-Number of Stays
	b. Covered Days	-Covered Days
	c. Length of Stay	-Length of Stay
	d. Charges	-Dollars
	e. Covered Charges	-Dollars
	f. Payment	-Dollars
	g. Lifetime Reserve Days	-Lifetime Reserve Days Used
	h. Coinsurance	-Coinsurance Days Used
4.	Intensive Care Unit Days	-Intensive Care Unit/Days plus Coronary Care Unit Days
5.	Intensive Care Unit Charges	-Intensive Care Unit/Charges plus Coronary Care Unit Charges
6.	Departmental Charges	-Departmental Charges
7.	Short Stay Data	
	a. Stays	-Number of Stays
	b. Covered Days	-Days-Covered Days
	c. Length of Stay	-Length of Stay
	d. Charges	-Dollars
	e. Covered Charges	-Dollars
	f. Payment	-Dollars
	g. Lifetime Reserve Days	-Lifetime Reserve Days Used
	h. Coinsurance Days	-Coinsurance Days Used

Skilled Nursing Facility Trailer

	Information	Description
1.	Type	-Value 'E'
2.	Year	-Reference year obtained from 'Admission Date' field
3.	Totals	
	a. Stays	-Number of Stays
	b. Covered Days	-Covered Days
	c. Length of Stay	-Length of Stay
	d. Charges	-Dollars
	e. Covered Charges	-Dollars
	f. Coinsurance Amount	-Dollars
	g. Payment	-Dollars
	h. Coinsurance Days	-Coinsurance Days Used

Exhibit A

Group Health Plan Trailer 1/

	Information	Description
1.	Plan Number	-ID Number of Group Health Plan (GHP) from GHP Master
2.	Status Code	-Current membership status -Active -Deceased -GHP Delete -SSA Termination
3.	Entitlement Type	-Combination of Medicare Entitlement code and GHP restriction. Present for HMO/HCPPP Only
4.	Part B Data	
	a. Part B Accretion	-Effective Julian date of Part B GHP Membership
	b. Part B Deletion	-Effective Julian date of Part B GHP Deletion
5.	Part A Data	
	a. Part A Accretion	-Effective Julian date of Part A GHP membership
	b. Part A Deletion	-Effective Julian date of Part A GHP Deletion

1/ Note: These are not yearly trailers. There is a trailer for each membership period.

X. End Stage Renal Disease Program Management and Medical Information System

Introduction

Persons with End Stage Renal Disease (ESRD) became eligible for Medicare benefits on July 1, 1973. The ESRD Program Management and Medical Information System (PMMIS) captures demographic, medical, reimbursement, and entitlement data on Medicare ESRD beneficiaries. The system also captures certification and other types of information on providers approved by Medicare to furnish kidney dialysis and transplant services, and contains aggregate patient population counts. (These are the only population counts that include non-Medicare patients along with Medicare beneficiaries.)

Source Documents and Input

Documents containing beneficiary-specific information are originated at local Social Security District offices and at renal provider levels. In addition, ESRD inpatient and outpatient billing records are maintained in the PMMIS and certain data are extracted and made a part of the beneficiary record. Aggregate patient population data are received annually from renal providers; and provider certification, Minimum Utilization Rates (MUR), and other provider characteristics are collected from the regional offices and/or intermediaries.

Update Mechanism and Quality Control Measures

The beneficiary-specific information is updated monthly. Master identification records are updated from identification records from the Health Insurance System. Beneficiary-specific records are edited and posted if valid. Records with errors are routed to an on-line file for correction. Inpatient and outpatient billing information is posted to the appropriate beneficiary record. At the conclusion of this batch updating, an M204 on-line data base is created containing much of the beneficiary-specific data from the batch files and is used for verifying and correcting data.

Provider certification and characteristic data are updated as received; aggregate patient population data are updated annually.

Hard copy data are reviewed and verified prior to keying by ESRD network organizations. The keyed data are processed through computer consistency and logic edits. Records rejected by the computer system are researched, corrected, and processed again through the system.

No other systems within HCFA are dependent on the PMMIS. The United States Renal Data System (USRDS), operated by the National Institutes of Health (NIH), relies on the PMMIS as its major source of data. PMMIS data bases are copied twice a year and provided to the NIH contractor. These became the USRDS main data base and are supplemented only by special data collections for one-time studies.

Dependent Systems and Outputs

Recurring tabulations, analyses, and reports are prepared on monthly and annual basis.

Special reports are prepared and analyses are performed to respond to requests from other components of HCFA and DHHS, the Congress, the renal professional community, the media, and various research organizations.

Exhibit A describes the beneficiary-specific portion of the PMMIS.

Exhibit B describes the provider characteristics and aggregate patient population data portion of the PMMIS.

ESRD PMMIS Identification Record

	Information	Description
1.	Record Identification Code	Identifies the record being processed
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3.	Cross-Reference Claim Number and Beneficiary Identification Code	Previous health insurance claim number and/or beneficiary's own social security number. Beneficiary identification code "**" indicates the beneficiary's own social security number. Identifies relationship to SSN.
4.	Type of PMMIS Transaction	Most recent transaction to PMMIS -Chronic Renal Disease Reimbursement Utilization Record (CRD RUS) -HI Master Identification Record -ESRD Transplant Record -ESRD Patient History Record/Medical Evidence Record -ESRD Dialysis Record -ESRD Hospital Record -Noncovered Bill Record -ESRD Death Notice Record -Master Record Cross-Reference Maintenance Record -Master Record Disabled Cross-Referencing -1978 Census Record
5.	Date PMMIS Transaction	Date of most recent transaction to PMMIS
6.	HIM Identification Post Date	Date HIM Master record posted to PMMIS
7.	Date of Accretion	Date record was accreted to the file
8.	Date of Birth	Julian date of beneficiary's birth
9.	Date of Death	Julian date of beneficiary's death

Exhibit A

	Information	Description
10.	Sex Code	Code which identifies the sex of the beneficiary (from Master File) -Unknown -Male -Female
11.	Race Code	Beneficiary race (From Master File) -Unknown -White -Black -Other
12.	Ledger Account File Code	Benefit payment status/reason for status
	Current Part A Dates	Dates refer to most recent entitlement to Medicare Part A (HI) benefits. Note: Entitlement to Part A (HI) and not Part B (SMI) is possible.
13.	Date of Entitlement	Julian date entitlement began
14.	Date of Termination	Julian date entitlement terminated
	Current Part B Dates	Dates refer to most recent entitlement to Medicare Part B (SMI) benefits
15.	Date of Entitlement	Julian date entitlement began
16.	Date of Termination	Julian date entitlement terminated
	Prior Part A Dates	
17.	Date of Entitlement	Julian date entitlement began. Zeroes indicate no entitlement.
18.	Date of Termination	Julian date entitlement terminated
	Prior Part B Dates	
19.	Date of Entitlement	Julian date entitlement began
20.	Date of Termination	Julian date entitlement terminated

	Information	Description
21.	HIM Source Date of Death	-All off -Master Beneficiary Record (MBR) -Medical bill -Beneficiary deceased, Source: MBR/Medical bill or clerical
22.	Early Entitlement Indicator	For internal use only -No early entitlement -Early entitlement
23.	Original Reason for Entitlement	Indicates reason for beneficiary's original entitlement to Medicare benefits -Old Age and Survivors Insurance (OASI) -Disability Insurance Benefits(DIB) -Renal -DIB and Renal
24.	Current Reason for Entitlement	Indicates reason for beneficiary's current entitlement to Medicare benefits -OASI -DIB -Renal -DIB and Renal

Exhibit A

	Information	Description
25.	End Stage Renal Disease Indicator	This code indicates the source (ESRD) of the notice of end stage renal disease. -No ESRD -MBR -HI -National Institutes of Health (NIH) -MBR and HI -MBR and NIH -HI and NIH -MBR, HI, and NIH -Clerical -MBR and Clerical -HI and Clerical -NIH and Clerical -MBR, HI, and Clerical -MBR, NIH, and Clerical -HI, NIH, and Clerical -MBR, HI, NIH, and Clerical
	Beneficiary Name	
26.	Beneficiary Surname	May be truncated
27.	Given Name	Given name. May be truncated.
28.	Middle Initial	Beneficiary's middle initial
	Beneficiary Address Data	
29.	State Code	SSA Standard State Code
30.	County Code	SSA Standard County Codes
31.	ZIP Code	May contain spaces or invalid codes
32.	Network of Residence	Determined from State and County Code
33.	HCFA Region	Determined from State Code

	Information	Description
	Beneficiary Address Prior Year	
34.	State Code	SSA Standard State Code
35.	County Code	SSA Standard County Codes
	Beneficiary Address 2 Years Prior	
36.	State Code	SSA Standard State Code
37.	County Code	SSA Standard County Codes
38.	Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81) or HCFA-2745 (1/82) received. -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
39.	Age ESRD PMMIS	Current age computed as of July 1 or as of July 1 of year of death
40.	First Date of ESRD Service	Earliest date of dialysis or transplant. Source: HCFA-1450, HCFA-2728, HCFA-2745
41.	Type of First ESRD Service	-Dialysis -Transplant
42.	Date Claim Number Crossed-Referred	Date HI cross-reference transaction is posted to PMMIS
43.	Investigation Code	For future use

Exhibit A

	Information	Description
44.	Source of Primary Provider Code	-Transplant provider, transplant functioning -Transplant provider, beneficiary died within 90 days of transplant -Dialysis provider, billed CAPD services in latest quarter -Dialysis provider, billed 21 most recent sessions -Dialysis provider, billed most sessions in latest 2 quarters -Transplant provider, HCFA-2728 -Dialysis provider, HCFA-2728
45.	Primary Provider	
	Epoetin (EPO) Data	
46.	EPO Start Date	-Date EPO was first administered
47.	Initial Hematacrit Level	-Hematacrit level when EPO was first administered
48.	Initial EPO Dosage	-Dosage of EPO that was initially administered
49.	Latest EPO Date	-Date EPO was most recently administered
50.	Latest Hematacrit Level	-Hematacrit level at most recent EPO administration
51.	Latest EPO Dosage	-Dosage of EPO for most recent administration
52.	Total EPO Administrations	-Total number of EPO administrations that beneficiary has received
53.	Total EPO Charges	-Total EPO charges for beneficiary
54.	M204 Database Indicator	For future use
55.	First Date of Dialysis	Earliest legitimate date

	Information	Description
56.	Source First Date of Dialysis	-Earliest HCFA-2728 -Earliest billed dialysis sessions, HCFA-1450, HCFA-2743 -DOEA (OREC = 2 or 3, EE1 = 1) -DOEA - 3 months (OREC = 2 or 3)
57.	Medicare Status Code	Indicates reason for Medicare entitlement as of a point in time. -Aged without ESRD -Aged with ESRD -DIB without ESRD -DIB with ESRD -ESRD only
58.	Current Dialysis Type	Most current reported type of dialysis -Hemodialysis -Peritoneal -Both -CAPD -CCPD
59.	Death Notification Provider	Provider submitting ESRD Death Notification, HCFA-2746
60.	Place of Death	Source: HCFA-2746, HCFA-1450 -Hospital -Dialysis Facility -Home -Other -Unreported
61.	Autopsy Indicator	Source: HCFA-2746 -Yes -No -Unreported

Exhibit A

	Information	Description
62.	Primary Cause of Death	Source: HCFA-2746 -Pericarditis (Including cardiac tamponade) -Myocardial infarction, acute -Cardiac (Other than pericarditis or myocardial infarction, acute) -Cerebrovascular (Including spontaneous subdural hematoma) -Embolism, air -Embolism, pulmonary -GI hemorrhage -Vascular access -Hemorrhage -Pulmonary infection -Septicemia -Viral hepatitis -Infection -Hyperkalemia -Pancreatitis -Malignancy -Withdrawal from dialysis -Suicide -Accidental death, treatment related -Accidental death, not treatment related -Unknown cause -Other (specify in remarks)
63.	Secondary Cause of Death	See primary causes above
64.	Batch Number HCFA-2746	Internal use (1983 to current)
65.	Transplant Status	Source: HCFA-1450, HCFA-2745, HCFA-2746 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
66.	Death Indicator	-HIM only -HCFA-2746 only -Both -No death indicator

	Information	Description
67.	Malignancy Indicator	Malignancy indicated Source: HCFA-2742 (expired 10/81), HCFA-2746
68.	Number of Medical Evidence Records	Number of RIC "B" records on the file
69.	Number of Transplant Records	Number of RIC "C" records on the file
70.	Number of Dialysis Records	Number of RIC "G" records on the file
71.	Number of Inpatient Stay Records	Number of RIC "E" records on the file
72.	Current Treatment Setting	Most current (date of service) reported treatment setting -Staff -Self-Care -Self-Care Training -Home -Inpatient -Transplant
	Most Current Data	
73.	Dialysis Provider	Dialysis provider reporting medical evidence. Source: HCFA-2728, Item 18; HCFA-2742, Item 9.
74.	Date of Dialysis	"Through date" of dialysis claim, first date of dialysis from HCFA-2728 if no billed date of dialysis Source: HCFA-1450, HCFA-2728
75.	Transplant Provider	Provider reporting transplant Source: HCFA-600-1, HCFA-2745, HCFA-1450
76.	Date of Transplant	Date of reported transplant

Exhibit A

	Information	Description
77.	Transplant Donor Type	Source: HCFA-600-1, HCFA-1450 -Monozygotic Twin -Dizygotic Twin -Sibling -Genetic Parent -Child -Cadaver -Other -Living Related -Unspecified (HCFA-1450)
78.	Inpatient Stay Date	Date of admission of reported inpatient stay. Source: HCFA-1450
79.	Number of HMO Periods	Count of number of HMO periods
80.	HMO Number	Plan number for HMO
81.	HMO Option Code	-HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills -HMO to process all Part A and Part B bills
82.	Current HMO Effective Date	Effective date of HMO period
83.	Current HMO Termination Date	Termination date of HMO period
84.	Prior HMO Number	Plan number of HMO
85.	Prior HMO Option Code	-HCFA to process all provider bills -HMO to process only in-plan Part A and in-area Part B bills -HMO to process all Part A and Part B bills
86.	Prior HMO Effective Date	Effective date of prior HMO period
87.	Prior HMO Termination Date	Termination date of prior HMO period

	Information	Description
88.	HMO Indicator	-Never in HMO -Deceased beneficiary had HMO involvement -Beneficiary was enrolled in HMO in the past -Beneficiary is currently enrolled in an HMO
89.	Resident Network	New Network designation
90.	Source Date Transplant Failure	Earliest of: -Date of subsequent transplant -Midpoint of first quarter after 22 sessions occurred. -Date of nephrectomy -Date of death (death occurred within 90 days of transplant) -Date of death (death occurred during transplant hospital stay) -Date of death (death notification form indicated transplant failed) -Date CAPD or CCPD began -Date returned to dialysis per 2728
91.	Date of Transplant Failure	Julian date
92.	Transplant Death	-Death occurred within 90 days of transplant or within the same hospital stay -Death occurred more than 90 days after transplant -No date of death
93.	Beneficiary Identification Code	Identifies beneficiary's relationship to SSN

Exhibit A

	Information	Description
94.	Possible Renal Activity Indicator	Errored records received -None -HCFA-2728 -HCFA-2745 -HCFA-2728, HCFA-2745 -HCFA-2746 -HCFA-2728, HCFA-2746 -HCFA-2728, HCFA-2745 -HCFA-2728, HCFA-2745, -HCFA-2746 -HCFA-1450 -other
95.	Date Most Current Errored Record	Links to Possible Renal Activity Indicator Field
96.	Recycle Indicator	For internal use
97.	Control Count	For internal use
98.	Delete Count	For internal use
99.	Date Last Update From HIM	Date most current HIM identification record posted
100.	Renal Indicator	-Clerically Set -Not clerically set -Data code 38 in HIM set using HCFA-1363

ESRD Medical Evidence Record

	Information	Description
	ESRD MEDICAL EVIDENCE RECORD	A record can occur for each period of ESRD entitlement Source: HCFA-2728 (10/81 to present) HCFA-2742 (1/77 to 9/81)
1.	Record Identification Code	Identifies the record format being processed
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3.	Medical Evidence Post	Date medical evidence record Date was posted to the PMMIS
4.	Primary Disease Causing ESRD	Code from International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
5.	Dialysis Provider	Dialysis provider reporting medical evidence Source: HCFA-2728, Item 18 HCFA- 2742, Item 9
6.	First Type of Regular Dialysis	-Hemodialysis -Peritoneal -Both -Continuous Ambulatory Peritoneal Dialysis (CAPD) -Continuous Cycling Peritoneal Dialysis (CCPD)
7.	Date Regular Dialysis Began	
8.	Transplant Provider	Provider reporting transplant
9.	Date of Transplant	Julian date of reported transplant
10.	Transplant Status	-Functioning -Rejected

Exhibit A

	Information	Description
11.	Date Returned to Dialysis	
12.	Self-Care Training Provider	Medicare-approved ESRD training provider
13.	Date Training Began	
14.	Type of Self-Care Training	-Hemodialysis -Peritoneal -CAPD -CCPD
15.	Date of Medical Certification	
16.	Source of Medical Evidence	-HCFA-2728 -HCFA-2742
17.	Processing Batch Number	For internal use

ESRD PMMIS Transplant--Pre-1982 Format

Information	Description
ESRD PMMIS TRANSPLANT INCIDENT	Source: HCFA-600-1 Transplant record, HCFA-1453 Inpatient record. Restricted use data file.
1. Record Identification Code	Identifies the record format being processed
2. Social Security Number and Beneficiary Identification Code	PMMIS Internal format. Converted from HIM format. Full code is retained as beneficiary identification code.
3. Transplant Record Post Date	Date transplant posted
4. Record Format Indicator	-Old format: 75 positions -HCFA-2745 format: 370 positions
5. Incident Counter	Ascending chronological sequence number distinguishing recurring records of this type
6. Transplant Provider	Provider reporting transplant Source: HCFA-600-1, HCFA-1453
7. Date of Transplant	Date of reported transplant
Donor Data	Following data pertain to organ donor Source: HCFA-600-1
8. Transplant Donor Type	-Monozygotic Twin -Dizygotic Twin -Sibling -Genetic Parent -Child -Cadaver -Other -Living related
9. Age at Transplant	

Exhibit A

Information	Description
10. Race Code	Source: HCFA-600-1, Item 13 Possible values -White -Black -Oriental -American Indian -Other -Unknown
11. Blood Type	Donor blood type
Recipient Data	Following data pertain to organ recipient
12. Race Code	Source: HCFA-600-1, Item 13. Possible values -White -Black -Oriental -American Indian -Other -Unknown
13. Sex Code	Code which identifies the sex of the beneficiary (from master file) -Unknown -Male -Female
14. Blood Type	Recipient blood type
15. Cross-Match Results	Source: HCFA-600-1, Item 15 -Unspecified -Not performed -Positive -Negative -Equivocal

	Information	Description
16.	Lymphocyte Culture	Source: HCFA-600-1, Item 16 -Unspecified -Not performed -Positive -Negative -Equivocal
17.	Date of Culture	Julian date. Source: HCFA-600-1, Item 16.
18.	Tissue Type Donor	Source: HCFA-600-1, Item 18. Codes indicating tissue type. -A-AW1 Series -A-AW2 Series -B-BW1 Series -B-BW2 Series -CW1 Series -CW2 Series
19.	Tissue Type Recipient	Source: HCFA-600-1, Item 17. Codes indicating tissue type. -A-AW1 Series -A-AW2 Series -B-BW1 Series -B-BW2 Series -CW1 Series -CW2 Series
20.	Days in Inpatient Hospital	Computed from HCFA-1453 discharge record
21.	Type of Inpatient Dialysis	-Hemodialysis -Peritoneal -Both -CAPD -CCPD
22.	Number of Dialysis Sessions	
23.	Hospital Indicator	For future use
24.	Recycle Indicator	For internal use

Exhibit A

	Information	Description
25.	Cross-Match Indicator	Indicates a cross-match was made -No -Yes
26.	Transplant Status	-Source: HCFA-1483, HCFA-1453, HCFA-600-1, HCFA-2746 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
27.	Inpatient Indicator	-HCFA-600-1 only, no stay record or AMCS record received -HCFA-600-1, and stay record posted -HCFA-600-1, stay record and AMCS record posted -No HCFA-600-1, stay record and AMCS record only

ESRD PMMIS Transplant -- Current Format

	Information	Description
1.	Record Identification Code	Identifies the record format being processed
2.	Social Security Number and Identification Code	PMMIS internal format. Converted from HIM format. Beneficiary Full code is retained as beneficiary indentification code.
3.	Transplant Record Post Date	Date transplant record posted to PMMIS
4.	Record Format Indicator	-Old format: 75 positions -HCFA-2745 format: 370 positions
5.	Incident Counter	Ascending chronological sequence number distinguishing recurring records of this type
6.	Transplant Provider	Provider reporting transplant. Source: HCFA-2745, HCFA-1450
7.	Date of Transplant	Date of reported transplant
8.	Transplant Donor Type	-Monozygotic twin -Dizygotic twin -Sibling -Genetic parent -Child -Cadaver -Other -Living Related -Unspecified
9.	Disposition Code	Original reply code

Exhibit A

	Information	Description
10.	Batch and Sequence	Assigned by clerical unit receiving record. This number represents- 4-position Date(YDDD) 1-position Type 2-position Sequence Field 2-positions (01 - 99) assigned electronically
11.	Days in Inpatient Hospital	Computed from HCFA-1450 discharge bill
12.	Type of Inpatient Dialysis	-Hemodialysis -Peritoneal -Both -CAPD -CCPD -Unspecified
13.	Number of Dialysis Sessions	
14.	Transplant Status	Source: HCFA-2745, HCFA-2746, HCFA-1450 -Transplanted, not on dialysis -Transplanted, on support dialysis -Transplanted, no additional information -Failed transplant -No transplant
15.	Inpatient Indicator	-HCFA-2745 only, no stay record or AMCS record received -HCFA-2745 and stay record posted -HCFA-2745, stay record and AMCS record posted -No HCFA-2745, stay record and AMCS record only
16.	Number of Pregnancies	

	Information	Description
17.	Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81); HCFA-2745 (1/82) received. Possible values -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
18.	Ethnicity	-Hispanic Origin -Not of Hispanic Origin
19.	Date of Transplant	Date of reported transplant
20.	Transplant Number	
21.	Date First Previous Failure	
22.	Date Second Previous Failure	
23.	Date Third Previous Failure	
24.	Provider Number	Provider identification number
25.	Surgeon's Name	
26.	Recipient Blood Group	
	Percent Reactive Antibody	
27.	High	Expressed as a percentage
28.	At Transplant	Expressed as a percentage
29.	MLC (1-Way)	
30.	MLC (2-Way)	
31.	MLC (Not Done)	
32.	Stim Index (1-Way)	

Exhibit A

	Information	Description
33.	Stim Index (2-Way)	
34.	Relative Response (1-Way)	
35.	Relative Response (2-Way)	
36.	HLA Haplotyped	
	Recipient Haplotype Data	
37.	Locus A1	
38.	Locus A2	
39.	Locus B1	
40.	Locus B2	
41.	Locus C1	
42.	Locus C2	
43.	Locus DR1	
44.	Locus DR2	
45.	Locus MB1	
46.	Locus MB2	
47.	Nephrectomy	-One -Two -No
48.	Date of Nephrectomy	
49.	Reason for Nephrectomy	Free fielded - Can contain up to 5 entries. -Uncontrolled hypertension -Infection -Reflux -Routine preparation for transplant -Other

	Information	Description
50.	Splenectomy	-Yes -No
51.	Date of Splenectomy	
	HBs AG Status	
52.	Positive Ever	
53.	Positive Now	
54.	Antibody to HBs AG	
55.	CMV Status: Antibody Present	-Yes -No -Unknown
	Blood Transfusion Data	
56.	Pre-Transplant	-Yes -No
57.	Number of Transfusions	
58.	Frozen Blood Used	
59.	Date of Last Transfusion	
60.	At Time of Transplant	-Yes -No
61.	Creatinine Decline	-Yes -No -Unknown
62.	Donor Type	-Cadaveric -Living related
63.	Cadaveric Type	-Local -Shared

Exhibit A

Information	Description
64. Living Related Type	-HLA Identical -Haplo Identical -Haplo Dissimilar -Identical Twin
Donor Data	
65. Sex Code	-Male -Female
66. Age at Transplant	Source: HCFA-2745, Item 22.
67. Blood Group	-O -A -B -AB
68. Race Code ESRD PMMIS	Posted from latest HCFA-2728 (10/81) or HCFA-2745 (1/82) received. Possible values -American Indian/Alaskan Native -Asian/Pacific Islander -Black -White -Unknown
69. Ethnicity	-Hispanic Origin -Not of Hispanic origin
70. Infections at Harvest: HBs AG Positive	-Yes -No -Unknown
71. Infections at Harvest: CMV Antibody	-Yes -No -Unknown
72. Infections at Harvest:	Other Infections-Positive sputum culture -gram negative bacteria -Positive urine culture greater than 10,000 per ml.

	Information	Description
72.	Infections at Harvest: (con.)	-Positive urine culture greater than 1,000,000 per ml. -Pneumonia - gram positive -Pneumonia - gram negative -Meningitis -Bacteremia during admission -All others -No -Unknown
73.	Cancer at Time of Harvest	-Intracranial -Extracranial -None -Both
74.	Haplotype	-Yes -No
75.	Locus A1	
76.	Locus A2	
77.	Locus B1	
78.	Locus B2	
79.	Locus C1	
80.	Locus C2	
81.	Locus DR1	
82.	Locus DR2	
83.	Locus MB1	
84.	Locus MB2	
85.	BUN	
86.	Serum Creatinine	
87.	Warm Ischemia Time (Minutes)	

Exhibit A

	Information	Description
88.	Cold Time (Hours)	
89.	Cold Time (Minutes)	
90.	Pulsatile Perfusion (Hours)	
91.	Pulsatile Perfusion (Minutes)	
	Pretreatment	
92.	Steroids	
93.	Diuretics	
94.	Diuretics (Mannitol)	
95.	Diuretics (Lasix)	
96.	Cyclophosphamide	
97.	Methylprednisolone and cyclophosphamide	
98.	Heparin	
99.	Other	
100.	Time Prior to Harvest	Time prior to harvest cyclophosphamide, methyprednisolone and cyclophosphamide or heparin given to the donor. -Given 0-5 hours prior -Given 5 or more hours prior

ESRD Quarterly Dialysis Record

	Information	Description
	ESRD QUARTERLY DIALYSIS RECORD	Each dialysis record represents an aggregation by provider of all dialysis claims received during a quarter. There may be multiple dialysis records for any given quarter depending on the number of providers submitting claims. Source: HCFA-2743 (1/77 - 3/81), HCFA-1450
1.	Record Identification Code	Identifies the record format being processed
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full code is retained as Beneficiary identification code.
3.	Dialysis Information Post Date	Date most recent dialysis information was posted to PMMIS
4.	Dialysis Sequence Number	Two Digits (01-99). Ascending chronological sequence counter of dialysis records.
5.	Year of Service	
6.	Quarter of Service	Calendar quarter in which the service was rendered
7.	Dialysis Provider	Dialysis provider reporting medical evidence. Source: HCFA-2728, Item 18; HCFA- 2742, Item 9.
	Dialysis Session Data	
8.	First Date of Service in Quarter	
9.	Last Date of Service in Quarter	
10.	Full Care in Unit	

Exhibit A

	Information	Description
11.	Self-Care in Unit	
12.	Self-Care Training	
13.	Home Care	
14.	Number of Input Records	Number of records merged to create quarterly record
15.	Current Dialysis Type	Source: HCFA-2743, HCFA-1450 Most current (date of service) reported type of dialysis -Hemodialysis -Peritoneal -Both -CAPD -CCPD
16.	Day of Dialysis Type Change	Day, within quarter, that dialysis type first changed
17.	Units of Blood	Units of blood billed during quarter. Source: HCFA-1450
18.	Previous Dialysis Type	First reported type of Dialysis within quarter -Hemodialysis -Peritoneal -Both -CAPD -CCPD
19.	Source of Dialysis Information	-HCFA-2743 -HCFA-1450
20.	Dialysis Setting	-Full Care Unit -Self-Care Unit -Self-Care Training -Home

	Information	Description
21.	Provider Certification Code Code	-Not Used -Dialysis Center -Hospital-based Facility -Non-Hospital Facility -Transplant/Dialysis Center -Inpatient Care Only -Not Certified

Epoetin (EPO) Data

22.	EPO Administration	Total EPO administrations for this quarter
23.	EPO Charges	Total EPO charges for this quarter
24.	EPO Dosage	Dosage from most recent EPO administration for this quarter
25.	Hematacrit Level	Hematacrit level from most recent bill for this quarter
26.	Dialysis Charges	Total dialysis charges for this quarter

Exhibit A

ESRD Inpatient Stay Record

	Information	Description
	ESRD PMMIS INPATIENT STAY RECORD	PMMIS does not include records for 1-day stays. Source: HCFA-1450
1.	Record Identification Code	Identifies the record format being processed
2.	Social Security Number and Beneficiary Identification Code	PMMIS internal format. Converted from HIM format. Full Code is retained as beneficiary identification code.
3.	Inpatient Stay Record Post Date	Date the inpatient stay information was posted to the PMMIS
4.	Stay Sequence Counter	Chronological sequence number of the stay
5.	Provider Number	Identifier for the provider of service
6.	Date of Admission	Julian date of admission to the provider.
7.	From Date	Julian date of first service
8.	Through Date	Julian date for last service on bill submitted
9.	Patient Status Code	-Discharge -Died -Still Patient -Visits Exhausted (HHA Only)
10.	Diagnosis Code	ICD-9-CM, left justified, blank filled
11.	DRG (Diagnostic Related Group) Code	Code assigned from HCFA-1450 to indicate diagnosis group for payment purposes

	Information	Description
12.	DRG Discharge Destination	-To home, self-care -To short term hospital -To SNF -To ICF -To other type facility -To home health service care -Left against medical advice
13.	DRG/Outlier Code	-No outlier -Day outlier -Cost outlier -Valid DRG received from intermediary -HCFA developed DRG -HCFA developed DRG using patient status code -Non groupable
14.	Surgical Procedure Code	
15.	Date of Surgery	Julian date of beneficiary's surgery
16.	Additional Surgery Indicator	Indicates the presence of additional surgery on the bill -No surgery involved -No additional procedure -Yes, additional procedure -Unknown
17.	Unibill Indicator	-HCFA-1450 format
18.	Number of Dialysis Sessions	
19.	Type of Inpatient Dialysis	-Hemodialyis -Peritoneal -Both -CAPD -CCPD -Unspecified

Exhibit A

	Information	Description
20.	Transplant During This Stay	Source: HCFA-1450, HCFA-2745
21.	Completeness of Stay Record	-Incomplete -Complete -Discharge
22.	Type of Medical Coding	-ICDA-8 -ICD-9-CM
23.	Kidney Acquisition Charge	Amount from inpatient bill
	Epoetin (EPO) Data	
24.	EPO Administrations	Total EPO administrations for this stay
25.	EPO Dosage	Dosage of EPO for this stay
26.	Hematacrit Level	Hematacrit level for this stay
27.	EPO charges	Total EPO charges for this stay

Facility Survey

	Information	Description
Provider Data		
1.	Provider Number	Facility identification number
2.	Provider Name	Name of facility
3.	Street Address	Street address of facility
4.	City	City of provider
5.	State	State abbreviation
6.	ZIP	5 position ZIP code
7.	CCPD	Code to indicate continuous cycling peritoneal dialysis
8.	Maintenance Hemo	Code to indicate staff-assisted hemodialysis at facility
9.	Maintenance Peri	Code to indicate staff-assisted peritoneal dialysis at facility
10.	Self-Care Hemo	Code to indicate in unit self-care hemodialysis at facility
11.	Self-Care Peri	Code to indicate in unit self-care peritoneal dialysis at facility
12.	Training Hemo	Hemo Code to indicate hemodialysis training at facility
13.	Training Peri	Code to indicate peritoneal dialysis training at facility
14.	CAPD Indicator	Indicates CAPD (continuous ambulatory peritoneal dialysis)
15.	Total Stations	Total number of dialysis stations at facility (Not always current)

Exhibit B

	Information	Description
16.	Certification Date	Date of certification to provide renal services
17.	Certification Type	Code indicating type of facility certification -Transplant Center -Dialysis Center -Dialysis Facility Hospital -Dialysis Facility -Transplant and Dialysis Center -Inpatient Care Only
18.	Survey Cert	Certification type used for Facility Survey purposes
19.	Prior Cert Date	Date of prior certification
20.	Prior Cert Type	
21.	Termination Date	Date of facility termination
22.	Termination Reason	Reason facility terminated, blank if no termination -Involuntary withdrawal -Failure to meet health and safety standards -Failure to meet minimum utilization rates (MUR) -Failure to meet need requirement -Closed -Other
23.	Prior Term Date	Date of prior termination.
24.	Prior Term Reason	-Involuntary withdrawal -Failure to meet health and safety standards -Failure to meet minimum utilization rates (MUR) -Failure to meet need requirement -Closed -Other

	Information	Description
25.	Medicare Cert Date	Date of approval for reimbursement of Medicare services
26.	Intermediary	Identification number of current fiscal intermediary authorized to process bills from this provider
27.	ESRD Current Network	Renal network number of the provider
28.	Region	HCFA Regional Office Code
29.	Old Network	Network designation as published in Federal Register
30.	MSA	FIPS MSA number (4 positions) 5th Position = Size -1 million or more -250,000 to 1 million -100,000 to 250,000 -Less than 100,000 Note: Size not completed
31.	SSA County Code	Geographic code assigned by SSA standards
32.	FIPS	Geographic code assigned by FIPS standards (Federal Information Processing Standard Code)
33.	Backup Provider	Backup dialysis provider - completed for free standing facilities
34.	Cross Refer No.	For internal use only
35.	Convert No.	Indicates provider number for either change of ownership, transfer of stations, or number change
36.	FY-end	Date of fiscal year end
37.	Telephone Number	Area code plus phone number of facility

Exhibit B

	Information	Description
38.	Type Ownership	Type of Ownership -Individual - For Profit -Partnership - For Profit -Corporation - For Profit -Other - For Profit -Individual - Not For Profit -Partnership - Not For Profit -Corporation - Not For Profit -Other - Not For Profit -State-Government Non-Federal -County-Government Non-Federal -City-Government Non-Federal -City/County-Government Non-Federal -Hospital District/Authority-Government Non-Federal -Other - Government Non-Federal -Veterans Administration - Government Federal -Public Health Service - Government Federal -Military - Government Federal -Other - Government Federal
39.	Skeleton Record	For internal use only
40.	Change Date	Date of last information change in file
41.	Beginning In-Unit	In-unit patients receiving care at beginning of Survey period
42.	Beginning Home	Home patients receiving care at beginning of Survey period
	Dialysis Patients	
43.	Beginning Total	Total patients receiving care at beginning of Survey period
44.	In-Unit First Start	In-unit started for first time ever - addition during Survey period
45.	Home First Start	Home started for first time ever - addition during Survey period

	Information	Description
46.	In-Unit Restarted	In-unit restarted - addition during Survey period
47.	Home Restarted	Home restarted - addition during Survey period
48.	In-Unit Transferred In	In-unit transferred from other dialysis unit - addition during Survey period
49.	Home Transferred In	Home transferred from other dialysis unit - addition during Survey period
50.	In-Unit Transplant Return	In-unit returned after transplantation - addition during Survey period
51.	Home Transplant Return	Home returned after transplantation - addition during Survey period
52.	In-Unit Deaths	In-unit deaths - losses during Survey period
53.	Home Deaths	Home deaths - losses during Survey period
54.	In-Unit Recovered	In-unit recovered kidney function -losses during Survey period
55.	Home Recovered	Home recovered kidney function - losses during Survey period
56.	In-Unit Received	In-unit received transplant - Transplant losses during Survey period
57.	Home Received Transplant	Home received transplant - losses during Survey period
58.	In-Unit Transferred Out	In-unit transferred to other dialysis unit - losses during Survey period
59.	Home Transferred Out	Home transferred to other dialysis unit - losses during Survey period

Exhibit B

	Information	Description
60.	In-Unit Discontinued	In-unit discontinued dialysis - losses during Survey period
61.	Home Discontinued	Home discontinued dialysis - losses during Survey period
62.	In-Unit Other	In-unit other (LTFU) - losses during Survey period
63.	Home Other	Home other (LTFU) - losses during Survey period
64.	Staff Hemo	Staff-assisted hemodialysis patients receiving care at end of Survey period
65.	Staff Peritoneal	Staff-assisted peritoneal dialysis patients receiving care at end of Survey period
66.	Hemo Training	Self-dialysis training hemodialysis patients receiving care at end of Survey period
67.	Peri Training	Self-dialysis training peritoneal dialysis patients receiving care at end of Survey period
68.	CAPD Self-dialysis	CAPD patients receiving care at end of Survey period
69.	CCPD	Self-dialysis CCPD patients receiving care at end of Survey period
70.	Total In-Unit	Total in-unit patients receiving care at end of Survey period
71.	Home Hemo	Hemodialysis home patients receiving care at end of Survey period
72.	Home Peri	Peritoneal dialysis home patients receiving care at end of Survey period
73.	Home CAPD	CAPD home patients receiving care at end of Survey period

	Information	Description
74.	Home CCPD	CCPD home patients receiving care at end of Survey period
75.	Total Home	Total home patients receiving care at end of Survey period
76.	Total Patients	Total patients receiving care at end of Survey period
77.	Medicare Enrolled	Currently enrolled in Medicare - patient eligibility status end of Survey period
78.	Application Pending	Medicare application pending -patient eligibility status end of Survey period
79.	Non-Medicare	Non-Medicare - patient eligibility status end of Survey period
80.	Home Hemo Completed Training	Home hemodialysis self-dialysis patients completing training
81.	Home Peri Completed Training	Home peritoneal dialysis - self-dialysis patients completing training
82.	CAPD Completed Training	CAPD self-dialysis patients completing training
83.	CCPD Completed Training	CCPD self-dialysis patients completing training
84.	Transient Patients Treated	Transient patients treated during Survey period
	Dialysis Treatments	
85.	Transient Treatments	Number of transient patient treatments during Survey period
86.	Outpatient SA Hemo Treatments	Number of outpatient staff-assisted hemodialysis treatments
87.	Outpatient SA Peri Treatments	Number of outpatient staff-assisted peritoneal treatments

Exhibit B

	Information	Description
88.	Hemo Training Treatments	Number of hemodialysis training treatments
89.	Peri Training Treatments	Number of peritoneal dialysis training treatments
90.	CAPD Training Treatments	CAPD training treatments
91.	CCPD Training Treatments	CCPD training treatments
	Kidney Transplants	
92.	Patients Transplanted	Patients who received transplant at this facility
93.	Medicare Patients Transplanted	Patients transplanted and currently enrolled in Medicare
94.	Medicare Application Pending	Patients transplanted and Medicare application pending
95.	US Non-Medicare Transplants	US Resident patients transplanted and non-Medicare
96.	Other Non-Medicare Transplants	Other patients transplanted and non-Medicare
97.	Living Related Donor Transplant	Living donor transplants performed
98.	Living Unrelated Donor Transplant	Living unrelated donor transplants performed
99.	Cadaveric Donor Transplants	Cadaveric donor transplants performed
100.	Total Transplants	Total transplants performed
101.	Dialysis Awaiting Transplant	Dialysis patients awaiting transplant
102.	Non-Dialysis Awaiting	Non-dialysis patients awaiting transplant

Information	Description
Disposition of Kidneys	
103. Harvested and Transplanted	Cadaver kidneys harvested and transplanted
104. Harvested and Sent U.S.	Cadaver kidneys harvested at this facility and sent to another facility in U.S.
105. Harvested and Sent Non-U.S.	Cadaver kidneys harvested at this facility and sent outside the U.S.
106. Harvested and Nonviable	Cadaver kidneys harvested at this facility and nonviable
107. Total Harvested	Total cadaver kidneys harvested at this facility
108. Obtained OPA and Transplanted	Cadaver kidneys obtained from another transplant hospital/OPA and transplanted at this facility
109. Obtained OPA and Sent U.S.	Cadaver kidneys obtained from another transplant hospital/OPA and sent to another facility in U.S.
110. Obtained OPA and Sent NON-U.S.	Cadaver kidneys obtained from another transplant hospital/OPA and sent to another facility outside the U.S.
111. Obtained OPA and Nonviable	Cadaver kidneys obtained from another transplant hospital/OPA and nonviable
112. Total OPA Obtained	Total cadaver kidneys obtained from another transplant hospital/OPA
113. Obtained OPO and Transplanted	Cadaver kidneys obtained from independent OPO and transplanted at this facility
114. Obtained OPO and Sent-U.S.	Cadaver kidneys obtained from independent OPO and sent to another facility in U.S.

Exhibit B

	Information	Description
115.	Obtained OPO and Sent-Non-U.S.	Cadaver kidneys obtained from independent OPO and sent to another facility outside the U.S.
116.	Obtained OPO and Nonviable	Cadaver kidneys obtained from independent OPO and nonviable
117.	Total OPO Obtained	Total cadaver kidneys obtained from independent OPO
118.	Obtained and Transplanted	Cadaver kidneys obtained from nontransplant hospital and transplanted at this facility
119.	Obtained and Sent U.S.	Cadaver kidneys obtained from nontransplant hospital and sent to another facility in U.S.
120.	Obtained and Sent-Non-U.S.	Cadaver kidneys obtained from nontransplant hospital and sent to another facility outside the U.S.
121.	Obtained and Nonviable	Cadaver kidneys obtained from nontransplant hospital
122.	Total Obtained	Total cadavar kidneys obtained from nontransplant hospital
123.	Total Cadaver Transplanted	Total cadaver kidneys transplanted at this facility
124.	Total Cadaver Sent-U.S.	Total cadaver kidneys sent to another facility in U.S.
125.	Total Cadaver Sent-Non-U.S.	Total cadaver kidneys sent to another facility outside the U.S.
126.	Total Nonviable	Total cadaver kidneys nonviable

	Information	Description
127.	Nonviable Research	Total nonviable kidneys used for research
128.	Nonviable Discarded	Total nonviable kidneys discarded
129.	Survey Year	Year of Survey

XI. Health Care Provider Cost Report Information System (HCRIS)

Introduction

HCRIS is the national data base for Medicare hospital cost report data. The data base contains specific financial and statistical cost report data from Medicare certified hospitals and hospital/health care facility complexes beginning with hospital fiscal years ending on or after January 1, 1982. HCRIS also contains Title V and/or Title XIX data to the extent that the Medicare Fiscal Intermediaries (FI's) are responsible for processing and settling the hospitals' cost reports for these Federal programs. HCRIS data is kept on different systems according to cost report version: (HCFA 2552-84, HCFA 2552-85, HCFA 2552-89).

A standardized minimum data set for each version has been created. These data sets use fixed field length structures (See Exhibit A, 2552-84 minimum data set record specifications (PPS-I). The minimum data sets are available in both SAS and Sequential Format. The HCFA 2552-85 data is further segregated by PPS year (PPS 2 through PPS 5).

HCFA-2552-81 (H180--Cost reporting periods ending on or after January 1, 1982, and before September 30, 1983).

HCFA-2552-83 (TEFRA--Cost reporting periods beginning on or after October 1, 1982, and before October 1, 1983).

HCFA-2552-84 (PPS-I--Cost reporting periods beginning on or after October 1, 1983, and before October 1, 1984).

HCFA-2552-85 (PPS-II--Cost reporting periods beginning on or after October 1, 1984, and before October 1, 1985).

HCFA-2552-85 (PPS-III--Cost reporting periods beginning on or after October 1, 1985, and before October 1, 1986).

HCFA-2552-85 (PPS-IV--Cost reporting periods beginning on or after October 1, 1986, and before October 1, 1987).

HCFA-2552-85 (PPS-V--Cost reporting periods beginning on or ofter October 1, 1987, and before October 1, 1988).

For detail greater than that provided by the minimum data sets, the HCRIS staff may develop new or modify existing software to provide custom output as required by the data user.

Source Data--Hospital Cost Reports

The cost report is a complex document which must accommodate large teaching hospitals as well as small rural hospitals. The number of cost centers in each can vary from 15 to more than 300. Each cost report can comprise up to 3,600 data fields. More than 15,000 cost reports are processed through HCRIS annually, including as submitted, final settled and reopened.

The HCRIS system maintains provider and tracking files that enable it to determine when a data extract is due from an FI as well as track the status of an extract from initial receipt onward. The HCRIS processing software begins with an FI generated file that was extracted from an electronically created cost report. This extract is created only after numerous math checks and edits have been applied by the FI's Automated Desk Review (ADR) software. The HCRIS software will reapply the edits and check for other inconsistencies that can occur during transmission. The final result on the HCRIS Master File is data that is much edited and perfected.

Footnotes

- Cost report data are occasionally received from FIs in hard copy form (Approximately 200 per year). This is because the original report that is received from the provider is in non-standard form and therefore not able to be run on the FIs ADR program. In these instances the HCRIS staff will manually extract some of the more pertinent data for input to a master file. Hard copies are usually submitted by providers with low or no Medicare utilization and by no charge/all inclusive type providers.

- The HCFA 2552-81 data system includes the base period cost report data used in the hospital specific PPS cost per discharge and the TEFRA target amount per discharge from the Form HCFA-1007.

HOSPITAL COST DATA FROM HCFA FORM 2552-84 FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1983, AND BEFORE OCTOBER 1, 1984

IDENTIFYING AND INFORMATIONAL DATA SOURCE: FORM HCFA-2552-84 WORKSHEET S-2

Field Name		Line(s)	Column(s)
F1	Provider Number--Hospital	1a	2
F2	Provider Number--Subprovider I	1b	2
F3	Provider Number--Subprovider II	1c	2
F4	Provider Number--Swing Bed SNF	1d	2
F5	Provider Number--Swing Bed ICF	1e	2
F6	Provider Number--Hospital Based SNF	1f	2
F7	Provider Number--Hospital Based ICF	1g	2
F8	Provider Number--Hospital Based Other Long Term Care Facility	1h	2
F9	Provider Number--Hospital Based HHA	1i	2
F10	Provider Number--Hospital Based CORF	1j	2
F11	Provider Number--Hospital Based ASC	1k	2
F12	Provider Number--Hospital Based Hospice	1l	2
F13	Hospital Name	1a	1
F14	Hospital Payment System Under Medicare (P = PPS, T = TEFRA, O = Other)	1a	5
F15	Cost Reporting Period Beginning Date (YYMMDD)	2	2
F16	Cost Reporting Period Ending Date (YYMMDD)	2	
F17	Number of Months in the Cost Reporting Period		
F18	Type of Control (See Table I for Key)	3	1
F19	Type of Hospital (See Table II for Key)	4a	1
F20	Management/Support Services Purchased (Y/N)	5a	1
F21	Funded Depreciation (Y/N)	6g	1
F22	County Code		
F23	MSA Code (SSA)		
F24	MSA Code (FIPS)		
F25	Fiscal Intermediary Number		
F26	Cost Report Status (See Table III for Key)		
F27	All Inclusive Rate Provider (Y/N)		
F28	New Provider (Y/N)		

Exhibit A

STATISTICAL DATA
SOURCE: FORM HCFA-2552-84 WORKSHEET S-3

Field Name		Line(s)	Column(s)
F29	General Service Beds Available, End of Period	1	1
F30	General Service Beds Days Available (Excl. Newborn)	1	2
F31	Intensive Care Beds Available, End of Period	2	1
F32	Intensive Care Beds Days Available (Excl. Newborn)	2	2
F33	Coronary Care Beds Available, End of Period	3	1
F34	Coronary Care Beds Days Available (Excl. Newborn)	3	2
F35	Other Special Care Unit Beds Available, End of Period	4-6	1
F36	Other Special Care Unit Bed Days Available (Excl. Newborn)	4-6	2
F37	Total Beds Available in the Facility, End of Period	18	1
F38	Total Bed Days Available in the Facility	18	2
F39	Number of Full-Time Interns and Residents--Hospital	8	3
F40	Number of Full-Time Interns and Residents--Facility	18	3
F41	Average Number of Employees (FTE's)--Hospital	8	6
F42	Average Number of Employees (FTE's)--Facility	18	6
F43	Average Number of Nonpaid Workers (FTE's)--Hospital	8	7
F44	Average Number of Nonpaid Workers (FTE's)--Facility	18	7
F45	Medicare Discharges (Incl. Deaths, Excl. Newborn)	8	9
F46	Medicaid Discharges (Incl. Deaths, Excl. Newborn)	8	10
F47	Total Discharges (Incl. Deaths, Excl. Newborn)	8	11

HOSPITAL INPATIENT DAYS
SOURCE: FORM HCFA-2552-84 WORKSHEET D-1, PARTS I AND II

Field Name		Line(s)	Column(s)
F48	Total Routine Days (Incl. Private Room and Swing-Bed Days, Excl. Newborn Days)	1	1
F49	Total Routine Days (Incl. Private Room Days, Excl. Swing-Bed and Newborn Days)	2	1
F50	Total Title XVIII Routine Days (Incl. Private Room Days Excl. Swing-Bed and Newborn Days)	9	1
F51	Total Title XIX Routine Days (Incl. Private Room Days Excl. Swing-Bed and Newborn Days)	9	1
F52	Total Title XVIII Medically Necessary Days (Excl. Swing-Bed Days)--Routine	14	1
F53	Total Title XIX Medically Neccesary Days (Excl. Swing-Bed Days)--Routine	14	1
F54	Intensive Care Total Inpatient Days	43	b
F55	Intensive Care Total Title XVIII Inpatient Days	43	d

HOSPITAL INPATIENT DAYS (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D-1, PARTS I AND II

Field Name		Line(s)	Column(s)
F56	Intensive Care Total Title XIX Inpatient Days	43	d
F57	Coronary Care Total Inpatient Days	44	b
F58	Coronary Care Total Title XVIII Inpatient Days	44	d
F59	Coronary Care Total Title XIX Inpatient Days	44	d
F60	Other Special Care Total Inpatient Days	45-47	b
F61	Other Special Care Total Title XVIII Inpatient Days	45-47	d
F62	Other Special Care Total Title XIX Inpatient Days	45-47	d
F63	Depreciation--Buildings and Fixtures, Before Reclassification or Adjustment	1	2
F64	Depreciation--Movable Equipment, Before Reclassification or Adjustment	2	2
F65	Direct Salaries--All General Service Cost Centers	3-24	1
F66	Direct Salaries--All Hospital Inpatient Cost Centers	25-30	1
F67	Direct Salaries--All Other Inpatient Cost Centers	31-36	1
F68	Direct Salaries--All Ancillary Service Cost Centers	37-59	1
F69	Direct Salaries--All Outpatient Service Cost Centers	60-62	1

TOTAL OPERATING COSTS
SOURCE: FORM HCFA-2552-84 WORKSHEET A

Field Name		Line(s)	Column(s)
F70	Direct Salaries--All Other Reimbursable Cost Centers	63-82	1
F71	Direct Salaries--All Special Purpose Cost Centers	83-94	1
F72	Direct Salaries--All Nonreimbursable Cost Centers	96-100	1
F73	Other Direct Cost--All General Service Cost Centers	1-24	2
F74	Other Direct Cost--All Hospital Inpatient Cost Centers	25-30	2
F75	Other Direct Cost--All Other Inpatient Cost Centers	31-36	2
F76	Other Direct Cost--All Ancillary Service Cost Centers	37-59	2
F77	Other Direct Cost--All Outpatient Service Cost Centers	60-62	2
F78	Other Direct Cost--All Other Reimbursable Cost Centers	63-82	2
F79	Other Direct Cost--All Special Purpose Cost Centers	83-94	2
F80	Other Direct Cost--All Nonreimbursable Cost Centers	96-100	2

Exhibit A

SUMMARY OF CHANGES IN CAPITAL ASSET BALANCES
SOURCE: FORM HCFA-2552-84 WORKSHEET A-7

Field Name		Line(s)	Columns(s)
F81	Beginning Balance--Land	1a	1
F82	Purchases--Land	1a	2
F83	Donations--Land	1a	3
F84	Disposals and Retirements-Land	1a	5
F85	Beginning Balance--Land Improvements	1b	1
F86	Purchases--Land Improvements	1b	2
F87	Donations--Land Improvements	1b	3
F88	Disposals and Retirements-Land Improvements	1b	5
F89	Beginning Balance--Buildings and Fixtures	1c	1
F90	Purchases--Buildings and Fixtures	1c	2
F91	Donations--Buildings and Fixtures	1c	3
F92	Disposals and Retirements-Buildings and Fixtures	1c	5
F93	Beginning Balance--Building Improvements	1d	1
F94	Purchases--Building Improvements	1d	2
F95	Donations--Building Improvements	1d	3
F96	Disposals and Retirements-Building Improvements	1d	5
F97	Beginning Balance--Fixed Equipment	1e	1
F98	Purchases--Fixed Equipment	1e	2
F99	Donations--Fixed Equipment	1e	3
F100	Disposals and Retirements Fixed Equipment	1e	5
F101	Beginning Balance--Movable Equipment	1f	1
F102	Purchases--Movable Equipment	1f	2
F103	Donations--Movable Equipment	1f	3
F104	Disposals and Retirements Movable Equipment	1f	5

ADJUSTMENTS TO TOTAL OPERATING COSTS
SOURCES: FORM HCFA-2552-84 WORKSHEETS A-8 AND A-8-2

Field Name		Line(s)	Columns(s)
F105	Related Organization Transaction	13	2
F106	Physicians' Remuneration--Total	101	1
F107	Physicians' Remuneration Professional Component	101	2
F108	Physicians' Remuneration Provider Component	101	3
F109	Number of Physicians' Hours Provider Component	101	5
F110	RCE Limit--Total	101	6
F111	RCE Disallowance--Total	101	7
F112	Adjustment for Physicians' Professional Services and Cost in Excess of RCE Limits	101	8

REIMBURSABLE OPERATING COSTS, BEFORE COST ALLOCATION
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART I

Field Name		Line(s)	Column(s)
F113	Depreciation--Buildings and Fixtures, After Reclassification and Adjustment	1	0
F114	Depreciation--Movable Equipment, After Reclassification and Adjustment	2	0
F115	All General Service Cost Centers	1-24	0
F116	All Hospital Inpatient Cost Centers	25-30	0
F117	All Other Inpatient Cost Centers	31-36	0
F118	All Ancillary Service Cost Centers	37-59	0
F119	All Outpatient Service Cost Centers	60-62	0
F120	All Other Reimbursable Cost Centers	63-82	0
F121	All Special Purpose Cost Centers	83-94	0
F122	All Nonreimbursable Cost Centers	96-100	0
F123	Total Reimbursable Costs	103	0

MEDICAL EDUCATION COSTS
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART I

Field Name		Line(s)	Columns(s)
	****NURSING SCHOOL****		
F124	Total Nursing School Costs	103	20
	****INTERNS and RESIDENTS IN APPROVED PROGRAMS****		
F125	All Paramedical Education Programs	22-24	21
F126	Adults and Pediatrics (General Routine Care)	25	21
F127	Intensive Care Unit	26	21
F128	Coronary Care Unit	27	21
F129	All Other Special Care Units	28-30	21
F130	Subprovider I	31	21
F131	Subprovider II	32	21
F132	Nursery	33	21
F133	Skilled Nursing Facility	34	21
F134	Intermediate Care Facility	35	21
F135	Other Long Term Care Facility	36	21
F136	Operating Room	37	21
F137	Recovery Room	38	21
F138	Delivery Room and Labor Room	39	21
F139	Anesthesiology	40	21
F140	Radiology--Diagnostic	41	21
F141	Radiology--Therapeutic	42	21
F142	Radioisotope	43	21

Exhibit A

COST OF INTERNS AND RESIDENTS
IN APPROVED PROGRAMS (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART I

Field Name		Line(s)	Columns(s)
F143	Laboratory	44	21
F144	Whole Blood and Packed Red Blood Cells	46	21
F145	Blood Storing, Processing, and Transfusion	47	21
F146	Intravenous Therapy	48	21
F147	Respiratory Therapy	49	21
F148	Physical Therapy	50	21
F149	Occupational Therapy	51	21
F150	Speech Pathology	52	21
F151	Electrocardiology	53	21
F152	Electroencephalography	54	21
F153	Medical Supplies Charged to Patients	55	21
F154	Drugs Charged to Patients	56	21
F155	Renal Dialysis	57	21
F156	All Other Inpatient Ancillary Cost Centers	58-59	21
F157	Outpatient Clinic	60	21
F158	Emergency	61	21
F159	All Other Outpatient Service Cost Centers	62	21
F160	Home Program Dialysis	63	21
F161	Ambulance Services	64	21
F162	Durable Medical Equipment--Rented	65	21
F163	Durable Medical Equipment--Sold	66	21
F164	All Other Reimbursable Cost Centers	67-68	21
F165	Home Program Dialysis Equipment 100 percent Medicare	69	21
F166	Intern-Resident Service (Not in Approved Programs)	70	21
F167	Administrative and General--HHA	71	21
F168	Skilled Nursing Care--HHA	72	21
F169	Physical Therapy--HHA	73	21
F170	Occupational Therapy--HHA	74	21
F171	Speech Pathology--HHA	75	21
F172	Medical Social Services--HHA	76	21
F173	Home Health Aide--HHA	77	21
F174	Medical Appliances/DME-Rented--HHA	78	21
F175	Medical Appliances/DME-Sold--HHA	79	21
F176	Home Delivered Meals--HHA	80	21
F177	Other Home Health Services--HHA	81	21
F178	CORF	82	21
F179	Kidney Acquisition	83	21
F180	Liver Acquisition	84	21
F181	Other Organ Acquisition	85	21

COST OF INTERNS AND RESIDENTS
IN APPROVED PROGRAMS (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART I

Field Name		Line(s)	Columns(s)
F182	Ambulatory Surgical Center	91	21
F183	Hospice	92	21
F184	All Other Special Purpose Cost Centers	93-94	21
F185	All Nonreimbursable Cost Centers	96-100	21
F186	Total Interns and Residents Costs (Approved Programs)	103	21
	****PARAMEDICAL EDUCATION****		
F187	Total Paramedical Education Costs	103	22-24

TOTAL CAPITAL - RELATED COSTS
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART II

Field Name		Line(s)	Column(s)
F188	Adults and Pediatrics (General Routine Care)	25	25
F189	Intensive Care Unit	26	25
F190	Coronary Care Unit	27	25
F191	All Other Special Care Units	28-30	25
F192	Subprovider I	31	25
F193	Subprovider II	32	25
F194	Nursery	33	25
F195	Skilled Nursing Facility	34	25
F196	Intermediate Care Facility	35	25
F197	Other Long Term Care Facility	36	25
F198	Operating Room	37	25
F199	Recovery Room	38	25
F200	Delivery Room and Labor Room	39	25
F201	Anesthesiology	40	25
F202	Radiology--Diagnostic	41	25
F203	Radiology--Therapeutic	42	25
F204	Radioisotope	43	25
F205	Laboratory	44	25
F206	Whole Blood and Packed Red Blood Cells	46	25
F207	Blood Storing, Processing, and Transfusion	47	25
F208	Intravenous Therapy	48	25
F209	Respiratory Therapy	49	25
F210	Physical Therapy	50	25
F211	Occupational Therapy	51	25
F212	Speech Pathology	52	25
F213	Electrocardiology	53	25

Exhibit A

TOTAL CAPITAL - RELATED COSTS (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET B, PART II

Field Name		Line(s)	Column(s)
F214	Electroencephalography	54	25
F215	Medical Supplies Charged to Patients	55	25
F216	Drugs Charged to Patients	56	25
F217	Renal Dialysis	57	25
F218	All Other Inpatient Ancillary Cost Centers	58-59	25
F219	Outpatient Clinic	60	25
F220	Emergency	61	25
F221	All Other Outpatient Service Cost Centers	62	25
F222	All Other Reimbursable Cost Centers	63-82	25
F223	All Special Purpose Cost Centers	83-85, 91-94	25
F224	All Nonreimbursable Cost Centers	96-100	25
F225	Total Capital - Related Costs	103	25

COSTS AFTER STEPDOWN
SOURCES: FORM HCFA-2552-84 WORKSHEET C
AND WORKSHEET B, PART I

Field Name		Line(s)	Column(s)
F226	Adults and Pediatrics (General Routine Care)	25	1
F227	Intensive Care Unit	26	1
F228	Coronary Care Unit	27	1
F229	All Other Special Care Units	28-30	1
F230	Subprovider I	31	1
F231	Subprovider II	32	1
F232	Nursery	33	1
F233	Skilled Nursing Facility	34	1
F234	Intermediate Care Facility	35	1
F235	Other Long Term Care Facility	36	1
F236	Operating Room	37	1
F237	Recovery Room	38	1
F238	Delivery Room and Labor Room	39	1
F239	Anesthesiology	40	1
F240	Radiology--Diagnostic	41	1
F241	Radiology--Therapeutic	42	1
F242	Radioisotope	43	1
F243	Laboratory	44	1
F244	PBP Clinic Lab Services-Program Only	45	1
F245	Whole Blood and Packed Red Blood Cells	46	1
F246	Blood Storing, Processing, and Transfusion	47	1

COSTS AFTER STEPDOWN (CONTINUED)
SOURCES: FORM HCFA-2552-84 WORKSHEET C
AND WORKSHEET B, PART I

Field Name		Line(s)	Column(s)
F247	Intravenous Therapy	48	1
F248	Respiratory Therapy	49	1
F249	Respiratory Therapy Limit Adjustment	49	2
F250	Physical Therapy	50	1
F251	Physical Therapy Limit Adjustment	50	2
F252	Occupational Therapy	51	1
F253	Speech Pathology	52	1
F254	Electrocardiology	53	1
F255	Electroencephalography	54	1
F256	Medical Supplies Charged to Patients	55	1
F257	Drugs Charged to Patients	56	1
F258	Renal Dialysis	57	1
F259	All Other Inpatient Ancillary Cost Centers	58-59	1
F260	Outpatient Clinic	60	1
F261	Emergency	61	1
F262	All Other Outpatient Service Cost Centers	62	1
F263	All Other Reimbursable Cost Centers	63-68	1
F264	Total Hospital Reimbursable Costs After Stepdown	101	1
F265	All Special Purpose Cost Centers	83-85, 91-94	25
F266	All Nonreimbursable Cost Centers	96-100	25

TOTAL FACILITY ANCILLARY CHARGES
SOURCE: FORM HCFA-2552-84 WORKSHEET C

Field Name		Line(s)	Column(s)
F267	Operating Room	37	6
F268	Recovery Room	38	6
F269	Delivery Room and Labor Room	39	6
F270	Anesthesiology	40	6
F271	Radiology--Diagnostic	41	6
F272	Radiology--Therapeutic	42	6
F273	Radiosotope	43	6
F274	Laboratory	44	6
F275	PBP Clinic Lab Services-Program Only	45	6
F276	Whole Blood and Packed Red Blood Cells	46	6
F277	Blood Storing, Processing, and Transfusion	47	6
F278	Intravenous Therapy	48	6
F279	Respiratory Therapy	49	6

TOTAL FACILITY ANCILLARY CHARGES (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET C

Field Name		Line(s)	Column(s)
F280	Physical Therapy	50	6
F281	Occupational Therapy	51	6
F282	Speech Pathology	52	6
F283	Electrocardiology	53	6
F284	Electroencephalography	54	6
F285	Medical Supplies Charged to Patients	55	6
F286	Drugs Charged to Patients	56	6
F287	Renal Dialysis	57	6
F288	All Other Inpatient Ancillary Cost Centers	58-59	6
F289	Outpatient Clinic	60	6
F290	Emergency	61	6
F291	All Other Outpatient Service Cost Centers	62	6
F292	All Other Reimbursable Cost Centers	63-68	6

HOSPITAL ANCILLARY CHARGES, TITLE XVIII, PART A
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART I

Field Name		Line(s)	Column(s)
F293	Operating Room	37	2
F294	Recovery Room	38	2
F295	Delivery Room and Labor Room	39	2
F296	Anesthesiology	40	2
F297	Radiology--Diagnostic	41	2
F298	Radiology--Therapeutic	42	2
F299	Radioisotope	43	2
F300	Laboratory	44	2
F301	PBP Clinic Lab Services-Program Only	45	2
F302	Whole Blood and Packed Red Blood Cells	46	2
F303	Blood Storing, Processing, and Transfusion	47	2
F304	Intravenous Therapy	48	2
F305	Respiratory Therapy	49	2
F306	Physical Therapy	50	2
F307	Occupational Therapy	51	2
F308	Speech Pathology	52	2
F309	Electrocardiology	53	2
F310	Electroencephalography	54	2
F311	Medical Supplies Charged to Patients	55	2
F312	Drugs Charged to Patients	56	2
F313	Renal Dialysis	57	2

HOSPITAL ANCILLARY CHARGES, TITLE XVIII, PART A (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART I

Field Name		Line(s)	Column(s)
F314	All Other Inpatient Ancillary Cost Centers	58-59	2
F315	Outpatient Clinic	60	2
F316	Emergency	61	2
F317	All Other Outpatient Service Cost Centers	62	2
F318	All Other Reimbursable Cost Centers	63-68	2
F319	Operating Room	37	3
F320	Recovery Room	38	3
F321	Delivery Room and Labor Room	39	3
F322	Anesthesiology	40	3
F323	Radiology--Diagnostic	41	3
F324	Radiology--Therapeutic	42	3
F325	Radioisotope	43	3
F326	Laboratory	44	3
F327	PBP Clinic Lab Services-Program Only	45	3
F328	Whole Blood and Packed Red Blood Cells	46	3
F329	Blood Storing, Processing, and Transfusion	47	3
F330	Intravenous Therapy	48	3
F331	Respiratory Therapy	49	3
F332	Physical Therapy	50	3
F333	Occupational Therapy	51	3
F334	Speech Pathology	52	3
F335	Electrocardiology	53	3
F336	Electroencephalography	54	3
F337	Medical Supplies Charged to Patients	55	3
F338	Drugs Charged to Patients	56	3
F339	Renal Dialysis	57	3
F340	All Other Inpatient Ancillary Cost Centers	58-59	3
F341	Outpatient Clinic	60	3
F342	Emergency	61	3
F343	All Other Outpatient Service Cost Centers	62	3
F344	All Other Reimbursable Cost Centers	63-68	3

HOSPITAL ANCILLARY
CAPITAL - RELATED COSTS, TITLE XVIII, PART A
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART II

Field Name		Line(s)	Column(s)
F345	Total Inpatient Ancillary Costs	101	3
F346	Operating Room	37	5

Exhibit A

HOSPITAL ANCILLARY CAPITAL - RELATED
COSTS, TITLE XVIII, PART A (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART II

Field Name		Line(s)	Column(s)
F347	Recovery Room	38	5
F348	Delivery Room and Labor Room	39	5
F349	Anesthesiology	40	5
F350	Radiology--Diagnostic	41	5
F351	Radiology--Therapeutic	42	5
F352	Radioisotope	43	5
F353	Laboratory	44	5
F354	Whole Blood and Packed Red Blood Cells	46	5
F355	Blood Storing, Processing, and Transfusion	47	5
F356	Intravenous Therapy	48	5
F357	Respiratory Therapy	49	5
F358	Physical Therapy	50	5
F359	Occupational Therapy	51	5
F360	Speech Pathology	52	5
F361	Electrocardiology	53	5
F362	Electroencephalography	54	5
F363	Medical Supplies Charged to Patients	55	5
F364	Drugs Charged to Patients	56	5
F365	Renal Dialysis	57	5
F366	All Other Inpatient Ancillary Cost Centers	58-59	5
F367	Outpatient Clinic	60	5
F368	Emergency	61	5
F369	All Other Outpatient Service Cost Centers	62	5
F370	All Other Reimbursable Cost Centers	63-68	5

TOTAL FACILITY INPATIENT ANCILLARY MEDICAL EDUCATION COSTS
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART III

Field Name		Line(s)	Column(s)
F371	Operating Room	37	1
F372	Recovery Room	38	1
F373	Delivery Room and Labor Room	39	1
F374	Anesthesiology	40	1
F375	Radiology--Diagnostic	41	1
F376	Radiology-Therapeutic	42	1
F377	Radioisotope	43	1
F378	Laboratory	44	1
F379	Whole Blood and Packed Red Blood Cells	46	1

TOTAL FACILITY INPATIENT
ANCILLARY MEDICAL EDUCATION COSTS (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART III

Field Name		Line(s)	Column(s)
F380	Blood Storing, Processing, and Transfusion	47	1
F381	Intravenous Therapy	48	1
F382	Respiratory Therapy	49	1
F383	Physical Therapy	50	1
F384	Occupational Therapy	51	1
F385	Speech Pathology	52	1
F386	Electrocardiology	53	1
F387	Electroencephalography	54	1
F388	Medical Supplies Charged to Patients	55	1
F389	Drugs Charged to Patients	56	1
F390	Renal Dialysis	57	1
F391	All Other Inpatient Ancillary Cost Centers	58-59	1
F392	Outpatient Clinic	60	1
F393	Emergency	61	1
F394	All Other Outpatient Service Cost Centers	62	1
F395	All Other Reimbursable Cost Centers	63-68	1

HOSPITAL ANCILLARY MEDICAL EDUCATION COSTS, TITLE XVIII, PART A
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART III

Field Name		Line(s)	Column(s)
F396	Operating Room	37	5
F397	Recovery Room	38	5
F398	Delivery Room and Labor Room	39	5
F399	Anesthesiology	40	5
F400	Radiology--Diagnostic	41	5
F401	Radiology--Therapeutic	42	5
F402	Radioisotope	43	5
F403	Laboratory	44	5
F404	Whole Blood and Packed Red Blood Cells	46	5
F405	Blood Storing, Processing, and Transfusion	47	5
F406	Intravenous Therapy	48	5
F407	Respiratory Therapy	49	5
F408	Physical Therapy	50	5
F409	Occupational Therapy	51	5
F410	Speech Pathology	52	5
F411	Electrocardiology	53	5
F412	Electroencephalography	54	5

Exhibit A

HOSPITAL ANCILLARY MEDICAL
EDUCATION COSTS, TITLE XVIII, PART A (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART III

Field Name		Line(s)	Column(s)
F413	Medical Supplies Charged to Patients	55	5
F414	Drugs Charged to Patients	56	5
F415	Renal Dialysis	57	5
F416	All Other Inpatient Ancillary Cost Centers	58-59	5
F417	Outpatient Clinic	60	5
F418	Emergency	61	5
F419	All Other Outpatient Service Cost Centers	62	5
F420	All Other Reimbursable Cost Centers	63-68	5

HOSPITAL OUTPATIENT CHARGES AND COSTS, TITLE XVIII, PART B
SOURCE: FORM HCFA-2552-84 WORKSHEET D, PART IV

Field Name		Line(s)	Column(s)
F421	Total Outpatient Charges--80%	101	2
F422	Total Outpatient Charges Preadmission Diagnostic Testing	101	3
F423	Total Outpatient Costs--80%	101	4
F424	Total Outpatient Cost Preadmission Diagnostic Testing	101	5

SUMMARY OF OPERATING COSTS IN TOTAL AND FOR MEDICARE
SOURCE: FORM HCFA-2552-84 WORKSHEET D-1, PARTS I AND II

Field Name		Line(s)	Column(s)
F425	General Inpatient Routine Service Cost Net of Swing-Bed Cost	27	1
F426	General Inpatient Routine Service Cost Net of Swing-Bed Cost and Private Room Differential	37	1
F427	General Inpatient Routine Service Cost Title XVIII	41	1
F428	Intensive Care Unit--Total Medicare Cost	43	e
F429	Coronary Care Unit--Total Medicare Cost	44	e
F430	All Other Special Care Units Total Medicare Cost	45-47	e
F431	Medicare Inpatient Ancillary Cost, Before Limitation	48	1
F432	Medicare Malpractice Costs	49	1
F433	Total Medicare Inpatient Operating Costs, Including Pass-Through Costs	50	1
F434	TEFRA Target Amount per Discharge	74	1
F435	Incentive/Penalty Payment	77	1

SUMMARY OF INPATIENT HOSPITAL PASS-THROUGH COSTS IN TOTAL AND FOR MEDICARE SOURCE: FORM HCFA-2552-84 WORKSHEET D-1, PART II

Field Name		Line(s)	Column(s)
F436	Capital - Related Costs Allocated to Routine	51	1
F437	Approved Medical Education Costs Allocated to Routine	52	1
F438	Combined Pass-Through Costs Allocated to Routine, Net of Pass-Throughs to Swing-Beds	55	1
F439	Intensive Care Unit--Total Capital Related Costs	57	a
F440	Coronary Care Unit--Total Capital Related Costs	58	a
F441	All Other Special Care Units Total Capital - Related Costs	59-61	a
F442	Intensive Care Unit--Total Medical Eucation Costs	57	b
F443	Coronary Care Unit--Total Medical Education Costs	58	b
F444	All Other Special Care Units--Total Medical Education Costs	59-61	b
F445	Routine Service--Combined Medicare Pass-Through Costs	62	e
F446	Intensive Care Unit--Combined Medicare Pass-Through Costs	64	e
F447	Coronary Care Unit--Combined Medicare Pass-Through Costs	65	e
F448	All Other Special Care Units Combined Medicare Pass-Through Costs	66-68	e
F449	Inpatient Ancillary Medicare Capital Related Costs	69	1
F450	Inpatient Ancillary Medicare Medical Education Costs	70	1
F451	Total Medicare Inpatient Operating Costs, Net of Pass-Through Costs	72	1
F452	Title V Paid Losses (Current and 4 Preceding Years)	6	1
F453	Title XVIII Paid Losses (Current and 4 Preceding Years)	6	2
F454	Title XIX Paid Losses (Current and 4 Preceding Years)	6	3
F455	All Other Paid Losses (Current and 4 Preceding Years)	6	4

APPORTIONMENT OF MALPRACTICE INSURANCE COSTS TO MEDICARE SOURCE: FORM HCFA-2552-84 WORKSHEET D-8, PARTS I AND II

Field Name		Line(s)	Column(s)
F456	Total Paid Losses (Current and 4 Preceding Years)	6	5
F457	Reimbursable Hospital Malpractice Insurance Premiums and/or Fund Contributions	16	1
F458	Part A Inpatient Hospital Services	1	1
F459	Reimbursable Interns and Residents Costs	3	2

Exhibit A

APPORTIONMENT OF MALPRACTICE
INSURANCE COSTS TO MEDICARE (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET D-8, PARTS I AND II

Field Name		Line(s)	Column(s)
F460	Part A Kidney Acquisition Cost Certified Transplant Centers Only	4	1
F461	Part B Kidney Acquisition Costs Certified Transplant Centers Only	4	2
F462	Reimbursable Malpractice Costs	5	2
F463	Reimbursable Teaching Physician Costs--Part A	6	1
F464	Reimbursable Teaching Physician Costs--Part B	6	2
F465	Total Part A Reimbursable Costs Before Deductibles, Coinsurance,and Return on Equity Capital	10	1
F466	Total Part B Reimbursable Costs Before Deductibles, Coinsurance, and Return on Equity Capital	10	2
F467	Part A Reimbursable Return on Equity Capital	14	1
F468	Part B Reimbursable Return on Equity Capital	14	2
F469	Part A Cost of Covered Services	33	1
F470	Part B Cost of Covered Services	33	2
F471	DRG Payments--Other Than Outlier Amounts	36A	1
F472	DRG Outlier Payments	36B	1
F473	Part A Deductibles	38	1
F474	Part B Deductibles	38	2
F475	Part B Coinsurance Based on Costs	41	2
F476	Part A Coinsurance	42	1
F477	Part B Coinsurance Based on Charges	42	2
F478	Bad Debts for Composite Rate ESRD Services	44A	2
F479	Part A Bad Debts, Net of Recoveries	44B	1
F480	Part B Bad Debts, Net of Recoveries	44B	2
F481	Indirect Medical Education Adjustment, PPS Only	55	1
F482	Total Part A Cost Reimbursable to Provider	56	1
F483	Total Part B Cost Reimbursable to Provider	56	2
F484	Part A Interim Payments	57	1
F485	Part B Interim Payments	57	2
F486	Part A Protested Amounts	59	1
F487	Part B Protested Amounts	59	2

FINANCIAL DATA
SOURCE: FORM HCFA-2552-84 WORKSHEET G

Field Name		Line(s)	Column(s)
F488	Total Current Assets	11	1-4
F489	Total Fixed Assets	27	1-4
F490	Total Other Assets	32	1-4
F491	Total Assets	33	1-4
F492	Total Current Liabilities	42	1-4
F493	Total Long Term Liabilities	49	1-4
F494	Total Liabilities	50	1-4
F495	Total Fund Balances	58	1-4

PATIENT REVENUES
SOURCE: FORM HCFA-2552-84 WORKSHEET G-2, PART I

Field Name		Line(s)	Column(s)
F496	Hospital Inpatient Routine Service Revenue	1	1
F497	Total Facility Inpatient Revenue	9	1
F498	Hospital Special Care Revenue	15	1
F499	Inpatient Ancillary Revenue	17	1
F500	Revenue from Outpatient Services Rendered in an Inpatient Setting	18	1
F501	Revenue from Inpatient Services Rendered in an Outpatient Setting	17	2
F502	Outpatient Services Revenue	18	2
F503	Total Facility Inpatient Revenue	25	1
F504	Total Facility Outpatient Revenue	25	2

FACILITY REVENUES AND EXPENSES
SOURCE: FORM HCFA-2552-84 WORKSHEET G-3

Field Name		Line(s)	Column(s)
F505	Total Patient Revenues	1	1
F506	Allowances and Discounts on Patients' Accounts	2	1
F507	Net Patient Revenues	3	1
F508	Total Operating Expenses	4	1
F509	Other Income - Contributions, Donations, Bequests, etc.	7	1
F510	Income from Investments	8	1

Exhibit A

FACILITY REVENUES AND EXPENSES (CONTINUED)
SOURCE: FORM HCFA-2552-84 WORKSHEET G-3

Field Name		Line(s)	Column(s)
F511	Total Nonpatient Revenue, Including Fields 509 and 510 above	26	1
F512	Total Other Expenses	31	1
F513	Net Income or (Loss)	32	1

FINANCIAL DATA FROM PROPRIETARY PROVIDERS
SOURCE: FORM HCFA-2552-84 SUPPLEMENTAL WORKSHEET F-1

Field Name		Line(s)	Column(s)
F514	Total Current Assets	10	2
F515	Total Fixed Assets	26	2
F516	Total Other Assets	32	2
F517	Total Assets	33	2
F518	Total Current Liabilities	41	6
F519	Total Long Term Liabilities	49	6
F520	Total Liabilities	50	6
F521	Total Capital	52	6

PPS I CAPITAL DATA SET CONTENTS
SOURCE: FORM HCFA-2552-84 HCRIS MASTER FILE

Field Name	
C8	Subprovider I Payment System (P = PPS, T = TEFRA, O = Other)
C10	Subprovider II Payment System (P = PPS, T = TEFRA, O = Other)
C28	Total Depreciation Reported on the Cost Report
C29	Funded Depreciation Balance at end of year
C30	Hospital Bed Days Available
C31	Total Facility Bed Days Available
C32	Hospital Interns and Residents in FTE's
C33	Total Facility Interns and Residents in FTE's
C34	Title XVIII Hospital Discharges
C35	Title XVIII Total Facility Discharges
C36	Total Discharges - Hospital
C37	Total Discharges - Total Facility
C38	Total Salaries (unadjusted - may include PBP compensation for patient care)
C39	Total Facility Direct Cost (adjusted for principles applicable under PPS)
C40	Total Facility Direct Cost (adjusted for principles applicable under PPS) - Net of Noneimbursable Cost

PPS I CAPITAL DATA SET CONTENTS (CONTINUED)

Field Name	
C41	Total Facility Cost (after cost finding) (adjusted for principles applicable under PPS)
C42	Total Facility Cost (after cost finding) (adjusted for principles applicable under PPS) Nonreimbursable Costs
C43	Total Facility Capital Related Cost
C44	Total Facility Capital Related Cost - Net of Nonreimbursable Costs
C45	Total Facility Medical Education Costs (after cost finding)
C46	Total Facility Medical Education Costs (after cost finding) - Net of Nonreimbursable Costs
C47	Total Facility Operating Costs (as defined under PPS)
C48	Total Facility Operating Costs (as defined under PPS) - Net of Nonreimbursable Costs
C49	Medicare Operating Costs Under PPS - Facility
C50	Medicare Inpatient Capital Related Cost (Excl. Return on Equity) - Facility
C51	Medicare Inpatient Medical Education Costs - Facility
C52	Return on Equity for Medicare Inpatient Hospital Services under PPS
C53	DRG Amount - Other Than Outlier Payments - Facility
C54	DRG Amount - Outlier Payments - Facility
C55	Recovery of Excess Depreciation (as applicable to Medicare inpatient hospital services)
C56	Gains and Losses from disposition of depreciable assets - PPS Components
C57	Total Inpatient Days - PPS Components
C58	Total Swing Bed Days - PPS Components
C59	Total Inpatient Days (excluding swing bed and newborn) - PPS Components
C60	Medicare Inpatient Days - PPS Components
C61	Medicare Swing Bed Days - PPS Components
C62	Total Facility Inpatient Days - Title XVIII
C63	Investment Income on Restricted Funds (1)
C64	Investment Income on Unrestricted Funds (1)
C65	Interest Income on Funded Depreciation (1)
C66	Operating Interest Expense (1)
C67	Capital - Related Interest Expense (1)
C68	Amount of Retroactive Adjustment to Return on Equity Capital Included in Worksheet E, Part III, Line 53, column 1 (1)
C69	Medicare Inpatient Capital Related Costs (Excl. Return on Equity) -Hospital
C70	Medicare Inpatient Direct Medical Education Costs - Hospital

(1) This item was obtained from financial records of hospitals selected for the 1200 Hospital Sample.

Exhibit A

DISPROPORTIONATE SHARE DATA SET CONTENTS
SOURCE: FORM HCFA-2552-84 HCRIS MASTER FILE

Field Name	
D1	Total Routine Service Costs (After Cost Finding)
D2	Total Special Care Unit Costs (After Cost Finding)
D3	Total Inpatient Operating Expenses (After Cost Finding)
D4	Total Facility Medical Education Costs, Adjusted
D5	Medical Education Costs, Inpatient Routine, Title XVIII
D6	Medical Education Costs, Special Care Unit, Title XVIII
D7	Medical Education Costs, Inpatient Ancillary, Title XVIII
D8	Total Facility Capital Costs
D9	Capital Costs, Inpatient Routine, Title XVIII
D10	Capital Costs, Special Care Unit, Title XVIII
D11	Capital Costs, Inpatient Ancillary, Title XVIII
D12	Total Facility Inpatient Days
D13	Total Medicare Inpatient Days
D14	Total Medicaid Inpatient Days
D15	Total Routine Inpatient Days
D16	Total Medicare Routine Inpatient Days
D17	Total Medicaid Routine Inpatient Days
D18	Total Intensive Care Unit Days
D19	Medicare Intensive Care Unit Days
D20	Medicaid Intensive Care Unit Days
D21	Total Facility Admissions, All Patients
D22	Total Facility Admissions, Medicare Patients
D23	Total Facility Admissions, Medicaid Patients

TABLES TO THE PPS I MINIMUM DATA SET

Table I: Type of Control

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Governmental, Federal
7 = Governmental, City-County
8 = Governmental, County
9 = Governmental, State
10 = Governmental, Hospital District
11 = Governmental, City
12 = Governmental, Other

Table II: Type of Hospital

1 = General Short Term
2 = General Long Term
3 = Tuberculosis
4 = Specialty Short Term
5 = Specialty Long Term
6 = Chronic Disease
7 = Psychiatric
8 = Other

Table III: Cost Report Status

A = Reopened
E = Settled with Audit
O = Audited, Not Settled (Sample Hospitals Only)
J = Settled without Audit
N = As Submitted

XII. Provider Specific File

Introduction

The Provider Specific File is developed by the intermediaries for use in the hospital prospective payment system pricing mechanism. A reimbursement price is computed for an individual inpatient hospital stay depending on the Diagnosis Related Group (DRG) the stay is classified in. The Provider Specific File is used in central office to support DRG recalibration; its completeness is measured by comparison to the POS file.

Each fiscal intermediary (FI) submits the file quarterly to central office via magnetic tape by duplicating the history of provider specific data elements from its PRICER software. In addition to completion checks, HCFA edits the record for its conformity to provider number ranges, data parameters, code range checks, and minimum/maximum dollar amounts. FI's are alerted if submissions are incomplete or in error and are required to resubmit a corrected version of the file. Exhibit A contains the record contents and description of the file.

Exhibit A

	Information	Description
1.	Provider Number	Alpha-numeric 6 character provider number
2.	Effective Date	Julian Date. The effective date of the provider's first PPS period or the first record for each provider. This date should be 1 day later than the end of the provider's original fiscal year. For subsequent records, for the same provider, this date is the effective date of the change.
3.	Waiver Indicator	Not waived (under PPS) waived (not under PPs)
4.	Provider Type	This field identifies providers that require special handling. Short term facility (may also be left blank) Sole commmunity provider Longterm Psychiatric Rehabilitation facility Pediatric Hospital distinct parts Rural referral center Indian Health Service Redesignated Rural - year 1 Redesignated Rural - year 2 Sole community/referral center provider Alcohol facility Cancer facility
5.	Current Census Division	Identifies the current census division: New England Middle Atlantic South Atlantic East North Central East South Central

	Information	Description
5.	Current Census Division (con.)	West North Central West South Central Mountain Pacific
6.	Provider PPS Blend Period	Present when forcing provider into a specific PPS period, otherwise blank or 0-8 NOTE: Once a provider is forced into a specific PPS period, use an additional record each successive period through PPS period 5. If not, the provider stays in the PPS period of the last record indefinitely. For sole community providers use an additional record for each successive period 0-8
7.	Metropolitan Statistical Area (MSA)	Enter the appropriate code for the metropolitan statistical area or 9999 for rural.
8.	Fiscal Year End	On the first record for each provider this is the fiscal year end of the provider's last year before PPS. (PPS bills will be accepted for dates after this date.) For subsequent provider records this only changes if the provider changes fiscal year end, e.g., a change of ownership.
9.	Case Mix Adjusted Cost Per Discharge	The PPS base year cost per discharge divided by the case mix index. Zero for new providers.

Exhibit A

	Information	Description
10.	Cost of Living Adjustment	The appropriate cost of living adjustment as listed below:

Area	FY 84	FY 85 (10/1/84 4/30/86)	FY 86 (5/1/86 9/30/86)	FY 87 - 89 (10/1/86 9/30/90)
Alaska	1.250	1.250	1.250	1.250
Oahu	1.200	1.225	1.225	1.225
Kauai	1.175	1.150	1.150	1.175
Maui	1.200	1.200	1.200	1.200
Molakai	1.200	1.200	1.200	1.200
Lanai	1.200	1.200	1.200	1.200
Hawaii	1.100	1.125	1.125	1.150
All Other	1.000	1.000	1.000	1.000

11.	Intern/Beds Ratio	The provider's intern/resident to bed ratio. Calculated by dividing the provider's full-time equivalent interns and residents by the number of available beds (as calculated in positions (50-54). Does not include interns and residents in anesthesiology who are employed to replace anesthetists or those assigned to excluded units. The count based upon the number of interns and residents assigned to the hospital on September 1. Zero for non-teaching hospitals.
12.	Special Provider Update Factor (PRUP)	This field only for hospitals that have special update factors because their base period ended prior to September 30, 1982. For example, provider 010010 has a special update factor of 1.17268 effective 840203. If its current cost reporting period under PPS ends 12/31/84, the

Information	Description
12. Special Provider (con.)	regular update factor would be 1.06003 and the new special update factor effective 850101 would be: 1.17268 * 1.06003 = 1.24308 Zero filled for non-PRUP hospitals.

NOTE: The effective date for PRUP changes computed this way is based upon cost reporting periods beginning on or after 10/1/84; i.e., a cost reporting period ending 9/30/84 has a PRUP effective 10/1/84; a cost reporting period ending 10/31/84 has its PRUP effective 11/01/84, etc.

13. Hospital Beds	Number of hospital beds. The number of adult and pediatric beds available for use by patients at the beginning of the cost reporting period. A bed means an adult bed, pediatric bed or newborn bed, maintained in a patient care area for patients in acute, long term or domiciliary areas of the hospital. Beds in labor rooms, birthing rooms, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences and other such areas which are regularly maintained and utilized for only a portion of the stay of patients, primarily for special procedures or not for inpatient lodging, are not termed "beds for this purpose."

Exhibit A

Information	Description
14. Disproportionate Share Percentage (DSH)	Disproportionate share adjusted For discharges occurring on or after May 1, 1986 and before October 1, 1990, an addditional payment for each PPS hospital that meets the criteria for serving a disproportionate share of low income patients. Place this factor in this field if the hospital qualifies for this additional payment. Edited to assure that the DSH adjustment factor does not exceed the following criteria: a. Urban hospital (location 18-21 is 0040-9340) with 100 or more beds (location 50-54 is 100 or higher)- the DSH adjustment factor can not exceed .1500; the maximum under the law. b. Urban hospital with less than 100 beds- the adjustment factor is .0500 c. Rural hospital (location 18-21 is 9999)- the adjustment factor is .0400 Pricer multiplies this percentage (expressed as a decimal) by the Federal portion and outlier payment to determine the DSH adjustment. "Zero" for hospitals that do not qualify.
15. Cost to Charge Ratio	Derived from latest settled cost report and corresponding charge data from the billing file. This amount is computed by dividing the Medicare Operating Cost (from the cost report) by the Medicare Covered Charge (from the billing file).

	Information	Description
16.	Case Mix Index	This field is the case mix index that has been calculated and published by HCFA for each hospital (based on 1981 cost and billing data) reflecting the relative costliness of that hospital's mix of cases compared to a national average mix.
17.	Date file corrected.	
18.	Intermediary number.	
19.	Fiscal Year Begin Date	Captured to identify providers with less than 365 days years
20.	Pass Thru Amount for Capital	Per diem amount derived from the cost report
21.	Pass Thru Amount For Direct Medical Education	Per diem amount derived from the cost report
22.	Pass Thru Amount	Per diem amount derived from the cost report
23.	Total Pass Thru Amount, Including Miscellaneous	Per diem amount derived from the cost report
24.	Supplemental Security Income Ratio	SSI ratio used to derive the disproportionate share adjustment
25.	Medicaid Ratio	Medicaid ratio used to derive the disproportionate share adjustment

XIII. Medicare Automated Data Retrieval System (MADRS)

Introduction

OSDM has implemented a new research data base and retrieval system known as the Medicare Automated Data Retrieval System (MADRS). MADRS facilitates obtaining person-based Medicare utilization data for specified Medicare beneficiaries or cohorts of beneficiaries; e.g., persons living in specified States and counties. It is no longer necessary to search hundreds of magnetic tapes each year to obtain Medicare utilization data to satisfy research, demonstration and decision support projects requiring person-level data. There are approximately 340 million bills per year, 20 million Part A and 320 million Part B, for approximately 23 million Medicare beneficiaries using services.

For service years 1984 and afterwards, the most commonly requested billing data fields are stored on-line for the following types of bills:

- Inpatient Hospital
- Inpatient Skilled Nursing Facility
- Outpatient
- Home Health Agency
- Hospice
- Part B Payment Records for place of service "other than office"
- Summary data for Part B Payment Records with place of service "office" as follows:
  - -- Total reasonable charges for type of service "medical care"
  - -- Total amount reimbursed for type of service "medical care"
  - -- Total reasonable charges for type of service, "other than medical care"
  - -- Total amount reimbursed for type of service "other than medical care"

Additionally, for each person with Medicare utilization in the year there will be personal identifiers such as HI claim number, date of birth, sex, State, county, and ZIP Code of residence.

The MADRS file is updated each month from bills that have been processed through the Health Insurance/Supplementary Medical Insurance administrative operations. We have the current year's data plus three prior years on-line or near-line storage. Earlier years are written to tape and are available for retrieval on a special request basis. Retrieval of MADRS can be made using a finder record similar to that currently used for the administrative bill retrieval process. Currently, retrieval can be made for specific beneficiaries using their Health Insurance Claim Number and year of service or using their

specific State and/or county code of residence. Future plans call for expansion to include other indices and linkage to an M204 data base.

Exhibits

A	MADRS Finder Records
B	Inpatient and SNF Data
C	Outpatient Data
D	HHA Data
E	Payment Record Data, Place of Service Office (Summarized Data)
F	Payment Record Data, Place of Service Other Than Office
G	Hospice Data

Medicare Automated Data Retrieval System Finder File

	Information	Description	Comments
1.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary ficiary. The alpha-numeric suffix (BIC) identifies the claimant.	If only the first 9 positions of the claim number are specified, records for all beneficiaries housed under the account will be accessed.
2.	State Code	SSA standard State Code	Use only if HI Claim Number above NOT completed. 1/
3.	County Code	SSA standard county Code	Use only if HI Claim Number above NOT completed. If used, State Code must be completed. If entire State required, complete State Code, leave County Code blank. 1/
4.	Request Number	Control number assigned by the retrieval process.	
5.	Subrequest Number	Same as 4. above.	
6.	Date of Retrieval Run	Inserted during retrieval process.	
7.	Utilization Data Code	Payment Records Inpatient Bills Outpatient Bills HHA bills SNF Bills Hospice	For each data type, code 0 if "Not Requested." All other entries will default to "Requested."

Exhibit A

	Information	Description	Comments
8.	Year(s) of Data Requested	2 Position year for as many as 4 years.	System begins with 1984 data and houses current year and 3 prior years online
9.	Record(s) Found for Request	Indication of Found/ Not Found inserted by retrieval process.	
10.	Requestor Use Area	For use at requestor's option. Does not affect retrieval process.	

1/ Selection will be made based on EITHER the beneficiaries' HI claim number or State/county of residence.

NOTE: As of 11/1/87, items 1, 2, and 3 described above have been implemented. The remaining items are intended as future enhancements.

MADRS
Inpatient and SNF Data

	Information	Description
1.	Record Identification Code	Part A bill
2.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
3.	State Code of Residence	SSA standard State code
4.	County Code of Residence	SSA standard county code
5.	ZIP Code of Residence	Standard code
6.	Date of Birth	Julian date of beneficiary's birth
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal

Exhibit B

	Information	Description
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12.	Date of Service	Julian date. Discharge date for final bills, through date for interim bills.
13.	Debit/Credit indicator	Tabling value of record (+, -).
14.	Reimbursement Amount	Amount paid by Medicare. Pass-through not included.
15.	Total Charges	Total charges as reported by the provider.
16.	Payment - Edit Code	- Covered I/P or SNF bill - Non-covered I/P or SNF bill
17.	Transaction Code	-Christian Science SNF -Psychiatric Hospital Facility -Tuberculosis Hospital Facility -General Care Hospital Facility -Regular SNF
18.	Query Code	Code indicating status of bill: -Interim Bill -Final bill -Discharge Notice (Non-covered Bill) -Debit Adjustment -Credit Adjustment
19.	Provider Number	Provider number shown on bill
20.	Distinct Part Code	-Psychiatric Unit -Rehabilitation Unit -Swing-Bed Hospital -Alcohol/Drug Unit

	Information	Description
21.	Diagnoses Codes	ICD-9-CM Coding - Maximum of 5 - Principal diagnosis is first.
22.	Date of First Procedure	Julian date of first procedure.
23.	Procedure Codes	ICD-9-CM Volume 3 - Maximum of 3
24.	Date of Second Procedure	Julian date of second procedure
25.	Date of Third Procedure	Julian date of third procedure
26.	Approval Date	Julian date claim approved
27.	PPS Indicator	-Covered by PPS -Not covered by PPS
28.	DRG	Diagnosis Related Group derived from diagnoses and procedures
29.	Discharge Destination Code	-To Home, Self Care -To Short-Term Hospital -To SNF -To ICF -To Other Type Facility -To Home, Health Service Care -Left Against Medical Advise -Died -Still Patient
30.	Medical Record Number	Assigned by provider to patient records
31.	Admission Date	Julian date
32.	From Date	Julian date of start date of this bill
33.	Length of Stay	-For final bills Number of days from admission to discharge. At least 1 is always assumed. -For interim bills - Coded 0
34.	Total Inpatient Days	Number of days from admission to "To Date" for all interim and final bills

Exhibit B

	Information	Description
35.	Inpatient Covered Days	Number of covered days
*36.	Disproportionate Share Rate	Rate reflecting indigent population served. This factor is included in reimbursement amount.
*37.	Indirect Medical Education Amount	Reimbursable amount for teaching hospitals only. Before FY 89, this was not part of the reimbursement amount. Effective FY 89, this item is part of the reimbursement amount.
*38.	Kidney Acquisition Charge	Actual cost to acquire a kidney. Not included in reimbursement amount.
*39.	Pass-Through Per Diem	Daily rate of provider's overhead apportioned to this bill. Not included in reimbursement amount.
40.	Coinsurance Amount	Total amount for coinsurance
41.	Primary Payor Code	Code indicating who is primarily responsible for payment -Working aged beneficiary/spouse with employer group health plan -ESRD beneficiary in the 12 month coordination period with an employer group health plan -Conditional payment by Medicare; future reimbursement expected -Automobile no-fault or any liability insurance -Worker's Compensation -PHS or other federal agency -Disabled beneficiary under age 65 with LGHP -Black Lung -Veterans Administration -Medicare is primary payor
42.	Primary Payor Amount	The amount of Medicare expenses paid by primary payor, zero for Medicare only bills.

Information	Description
43. Pass-Through Source Code-Bill	-Cost Report -No pass-through available -Bill
* PPS Hospitals only	-Estimates

Exhibit C

MADRS
Outpatient Data

	Information	Description
1.	Record Identification Code	Part B bill other than payment record.
2.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
3.	State Code of Residence	SSA standard State code
4.	County Code of Residence	SSA standard county code
5.	Zip Code of Residence	Standard code
6.	Date of Birth	Julian date of beneficiary's birth
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal

	Information	Description
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12.	Date of Service	Julian date of last service
13.	Debit/Credit Indicator	Tabling value of record (+, -)
14.	Reimbursement Amount	Amount paid by Medicare
15.	Total Charges	Total charges
16.	Payment - Edit Code	Code that indicates this is an outpatient bill
17.	Transaction Code	Code indicating type of facility: -Outpatient
18.	Query Code	Code indicating status of bill: -Interim Bill -Final Bill -Debit Adjustment -Credit Adjustment
19.	Provider Number	Provider number shown on bill
20.	Diagnoses Codes	ICD-9-CM Coding - Maximum of 5
21.	Date of First Procedure	Julian date
22.	Procedure Codes	HCPCS Coding beginning 7/87 Maximum of 3 Earlier ICD-9-CM, Volume 3
23.	Date of Second Procedure	Julian date

Exhibit C

	Information	Description
24.	Date of Third Procedure	Julian date
25.	Approval Date	Date claim approved - Julian date
26.	HCPCS Codes	HCPCS Surgical Procedure 1/ Codes - Maximum of 3
27.	Date of 1st HCPCS Procedure	Julian date. 1/
28.	Date of 2nd HCPCS Procedure	Julian date. 1/
29.	Date of 3rd HCPCS Procedure	Julian date. 1/

1/ Available only for services after 7/1/87.

MADRS
HHA Data

	Information	Description
1.	Record Identification Code	-Part A -Part B
2.	HI Claim Number	The 9 digit numeric protion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
3.	State Code of Residence	SSA standard State code
4.	County Code of Residence	SSA standard county code
5.	Zip Code of Residence	Standard code
6.	Date of Birth	Julian date of beneficiary's birth
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB amd Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal

Exhibit D

	Information	Description
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12.	Date of Service	Julian date date of last service
13.	Debit/Credit Indicator	Tabling value of record (+, -)
14.	Reimbursement Amount	Amount paid by Medicare
15.	Total Charges	Total charges
16.	Payment-Edit Code	Code indicating this is an HHA bill
17.	Transaction Code	Code indicating type of facility: -HHA
18.	Query Code	Code indicating status of bill: -Interim Bill -Visits Exhausted (HHA) -Final Bill -Debit Adjustment -Credit Adjustment
19.	Provider Number	Provider number of HHA bill
20.	Diagnoses Codes	ICD-9-CM Code - Maximum of 5
21.	Approval Date	Julian date claim approved
22.	Patient Status	-Died -Still Patient -Visits Exhausted
23.	Service From Date	Julian beginning date of stay or service

	Information	Description
24.	Total HHA Visits	Home Health Agency visits
25.	Total HHA Visit Charges	Total charges for HHA visits

Exhibit E

MADRS
Payment Record Data - Place of Service Office

NOTE: These records are summarized to a single record per beneficiary for each calendar year (repeated by type of service Medical and type of service Non-Medical).

	Information	Description
1.	Record Identification Code	Part B payment record
2.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
3.	State Code of Residence	SSA standard State code
4.	County Code of Residence	SSA standard county code
5.	Zip Code of Residence	Standard code
6.	Date of Birth	Julian date of beneficiary's birth
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Original Reason For HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Reimbursement Amount	
11.	Total Allowed Charges	This field is the sum of medical charges plus psychiatric charges.
12.	Summary Indicator	This field contains a constant "SUMRY."

	Information	Description
13.	Place of Service	Office
14.	Type of Service	-Medical Care -Other than Medical Care

NOTE: Place of service and type of service are determined by largest allowed charge reported on bill.

Exhibit F

MADRS
Payment Record Data - Place of Service Other Than Office

	Information	Description
1.	Record Identification Code	Part B payment record
2.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
3.	State Code of Residence	SSA standard State code
4.	County Code of Residence	SSA standard county code
5.	Zip Code of Residence	Standard code
6.	Date of Birth	Julian date of beneficiary's birth
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal

	Information	Description
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12.	Date of Service	Julian date of date of last service
13.	Debit - Credit Indicator	Tabling value of record (+, -)
14.	Reimbursement Amount	Amount paid by Medicare
15.	Total Allowed Charges	This field is the sum of medical charges plus psychiatric charges.
16.	Entry Code	A code for type payment record being submitted: -Original debit -Supplemental -Full credit -Partial credit -Replacement debit -Partial debit -Correction record acknowledges full overpayment; also acknowledges an A reject previously submitted -Correction record acknowledges partial overpayment
17.	Entry Re-Code	-Initially submitted, accepted records -Resubmitted accepted records -Initially submitted, rejected records -Resubmitted rejected records
18.	Carrier Number	Carrier number from payment record

Exhibit F

	Information	Description
19.	Place of Service	-Home -Inpatient Hospital -SNF/Nursing Home -Outpatient Hospital -Independent Laboratory -Other -Independent Kidney Disease Treatment Center
20.	Type of Service	-Medical Care -Surgery -Consultation -Diagnostic X-Ray -Diagnostic Laboratory -Radiation Therapy -Anesthesia -Assistance at Surgery -Other Medical Service -Charges for whole blood or packed red blood cells -Purchase or rental of used DME -Surgical second opinion -Surgical third opinion blank for per diem records -Alternate payment method for maintenance dialysis -Live kidney donor
21.	Specialty Code	Physician or supplier specialty code
22.	Date Paid	Year and Julian date

NOTE: Place of Service and Type of Service are determined by largest allowed charge reported on bill.

MADRS
Hospice Data

	Information	Description
1.	Record Identification Code	-Part A bill -Part B payment record -Part B bill other than payment record
2.	HI Claim Number	The 9 digit numeric portion identifies the primary beneficiary. The alphanumeric suffix (BIC) identifies the claimant.
3.	State Code of Residence	SSA standard State code
4.	County Code of Residence	SSA standard county code
5.	Zip Code of Residence	Standard code
6.	Date of Birth	Julian date of beneficiary's birth
7.	Sex	Sex code from HI Master Record: -Male -Female -Unknown
8.	Race	Race code from HI Master Record: -White -Black -Other -Unknown
9.	Current Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal
10.	Original Reason for HI Entitlement	-OASI -DIB -Renal -DIB and Renal

Exhibit G

	Information	Description
11.	Medicare Status Code	Code to show reason for beneficiary's entitlement to Medicare benefits: -Aged without ESRD -Aged with ESRD -Disabled without ESRD -Disabled with ESRD -ESRD only
12.	Date of Last Service	Julian date of date of last service.
13.	Debit/Credit Indicator	Tabling value of record (+, -)
14.	Reimbursement Amount	Amount paid by Medicare
15.	Total Charges	Total charges
16.	Payment - Edit Code	Code indicating this is a hospice bill
17.	Transaction Code	Codes indicating type of facility: -Hospice
18.	Query Code	Code indicating status of bill: -Interim Bill -Final Bill -Debit Adjustment -Credit Adjustment
19.	Provider Number	Provider number of hospice
20.	Diagnosis Codes	ICD-9-CM Code - Maximum of 5
21.	Approval Date	Julian date claim approved

Information		Description
22.	Hospice Discharge Destination	- To home, self care - To Short Term Hospital - To SNF - To ICF - To other type facility - To home, Health Service care - Left against medical advice - Still patient - Died at home - Died in a medical institution - Place of death unknown
23.	Hospice Period Number	1, 2, or 3
24.	Service From Date	Julian beginning date of stay or service
25.	Hospice Start Date	Julian date
26.	Inpatient Days of Care	Total Inpatient days of care
27.	Length of Billing Period	Number of days from date of first service through date of last service. Must be at least 1.

XIV. Medicaid Data Collection

Introduction

The Office of Statistics and Data Management collects Medicaid eligibility, expenditure, and recipient data through two sources:

1. HCFA-2802 hard-copy report, and

2. Medicaid Statistical Information System (Tape Option)

All States are required to submit form HCFA-2082. This report contains summary counts for Medicaid recipients and services, categorized by types of services and demographic variables. States were given an option to provide HCFA copies of their Eligibility and paid claims data in place of the hard-copy report, enabling HCFA to fulfill the reporting requirement. States who volunteered to provide raw claims and eligibility data, and for whom the 2082 report generated by HCFA was deemed acceptable, have been exempted from the hard-copy reporting requirement. When a State is exempt from the hard-copy reporting option the State must provide copies of its claims and eligibility data to HCFA timely, enabling OSDM to create its HCFA-2082 reports.

HCFA-2082 Medicaid Statistics Report

Form HCFA-2082, Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, contains Medicaid cost and utilization data provided annually by States, territories, and the District of Columbia. The report captures summary data on Medicaid eligibles, recipients, service utilization, and Medicaid vendor payments from the States.

Previously all States reported on the "old" HCFA-2082 form dated April 1980 for FY 80 through FY 83. Beginning in FY 84 States were given an option of using a "new" HCFA-2082 form dated October 1984, or participating in the "tape option" project. For both the 1980 and 1984 reports, sections A and B are formatted identically. However, the remaining sections are organized or identified in such a manner that similar information is contained in different sections of the document. That is, section C of the 1980 report does not correspond to section C of the 1984 report. Exhibit A contains a sectional description of the 1984 form content.

Medicaid Statistical Information System

The Medicaid Statistical Information System (Tape Option) captures medicaid information at the individual claim level rather than in aggregate as the HCFA-2082 does. Participating States provide information on their Medicaid Eligible population along with copies of all medical services claims reimbursed with Medicaid (Title XIX) dollars. These data are furnished on a Federal Fiscal Year quarterly schedule, which begins October 1 of each year.

Each eligible is identified by means of a Personal Unique Identification Number (PUIN) that is assigned by the state. Some states use social security numbers as PUINs. All other

states create their own PUINs according to some systematic scheme that is approved by HCFA. Those states using the SSN as the PUIN are identified as SSN-States while those states that create the PUIN are called Non-SSN States.

A. The Eligible File

- one record for each person who was eligible for Medicaid for at least one day during the reporting quarter;
- one record for each individual for whom retroactive eligibility was established during the reporting quarter and for each prior reporting quarter covered by the retroactive eligibility;
- corrections to ELIGIBLE File records submitted in prior quarters.

Exhibit B contains a description of the eligible file content.

B. The Claims Files

Claims files contain several types of valid records: current claims for medical services, adjustments to previously paid claims, premium payments, and dummy claims. Dummy claims simulate claims that would have been generated for HMO/PHP patients if they were billed on a fee-for-service basis. Additionally some states use zero-dollar claims for special purposes, such as tracking individual services covered in a lump sum billing. To facilitate these differences, three distinct claims files are utilized rather than one. The three claims files have similar logical structures. The differences among the three files lie in the kinds of services they report and in some of the detailed information required by each group of services.

CLAIM-IP file records identify Title XIX claims for inpatient hospital services.

CLAIM-LT file records identify Title XIX claims for long term care services received in an institution. The phrase "long term care" includes services received in:

- Skilled Nursing Facilities (SNFs);
- Intermediate Care Facilities, including Intermediate Care Facilities for the Mentally Retarded (ICFs, ICF-MRs);
- Psychiatric Hospitals; and
- Independent (free-standing) psychiatric wings of acute care hospitals.

CLAIM-OT file records cover all Medicaid claims that are not included in either the CLAIM-IP file or the CLAIM-LT file. This includes:

- Provider claims for all non-institutional Medicaid services;
- Provider claims for all services received in hospitals, SNFs, or ICFs that are not billed as part of a long term care or inpatient claim, such as claims for physician visits, prescription drugs, services of private duty nurses, etc;
- HMO/PHP premium payments; and
- Claims for medical and non-medical services received under an approved Title XIX waiver.

Exhibit C contains a description of the Claims file content.

C. Files Created from The State Eligibility and Claims Data

Three distinct systems of records are generated from the State files submitted for inclusion into the Medicaid Statistical Information System:

1. Detailed validated (VALID Tapes) files contain the individual eligible and claim records submitted by the States. These files serve as the historical source of detailed Medicaid Eligibility and paid claims data maintained by DMS, and are the source of individual paid claims and Eligible information that will be used to build specialized research files.

2. PERSONAL SUMMARY RECORD FILE An Eligible (Personal) Summary file is compiled for each State, for the current ("year to date") Federal Fiscal Year. Files for the previous reporting year are also available on-line at the HCFA Data Center in a database environment. Each file contains one record for every person reported eligible for Medicaid during any portion of the Federal reporting year. The information in this file includes: demographic data, eligibility classifications, days and months of eligibility, days of care, number of discharges, Medicaid cost, Medicare deductible, coinsurance payments, type of insurance coverage, types of services received with related cost, and quantities of services received. This file can successfully address most data studies and reporting needs that are recipient oriented.

3. Tape Option HCFA-2082 TOTALS FILE. These data are in a highly aggregated format, in an on-line database, which contains summarized eligibility, recipient and claim expenditure information similar to the HCFA-2082 report. These data are also available in a flat file format that includes data captured from the HCFA-2082 hard-copy report. The hard-copy report is received from all States that are not participating in the Medicaid Statistical Information System project.

Exhibit A

Medicaid Statistics File from Form HCFA-2082 (1984)

2082 Section	Description
A	Recipients of medical care by type of medical service and by maintenance assistance status and basis of eligibility.
B	Amounts of medical vendor payments by type of medical service and by maintenance assistance status and basis of eligibility.
C	Number of Medicaid eligibles by length of eligibility, and maintenance assistance status and basis of eligibility.
D	Eligibles, recipients, and amounts of medical vendor payments by: - age, race/ethnicity, and sex; and - age, basis of eligibility, and maintenance assistance status.
E	Recipients, discharges, and days of care for inpatient general hospital by maintenance assistance status and basis of eligibility.
F	Recipients and days of institutional care by maintenance assistance status and basis of eligibility.
G	Recipients of medical care by age, sex, and race/ethnicity, and by type of medical service.
H	Amounts of medical vendor payments by age, sex, and race, ethnicity, and by type of medical service.
I	Recipients of institutional medical care by type of medical service, and by maintenance assistance status and basis of eligibility.
J	Amounts of medical vendor payments for recipients of institutional medical care by type of medical service, and by maintenance assistance status and basis of eligibility.
K	Premiums of per capita payments and eligibles by maintenance assistance status and basis of eligibility.
L	Recipients and payments by relationships of payment to Title XVIII deductibles and coinsurance and by type of medical service.

2082 Section	Description
M	Number of visits for selected types of services and number of prescriptions by maintenance assistance status and basis of eligibility.
N	Recipients and amounts of medical vendor payments for health programs other than Title XIX by type of medical service.

Exhibit B

Eligibility File Content

Each quarterly Eligible record consist of root data (personal information) and monthly enrollment data. The monthly enrollment data is present for each month of the reporting quarter in which the individual was eligible for Medicaid.

Field Name	Field Contents
Root Fields:	
COUNTY-CODE	FIPS code indicating eligible's county of residence.
DATE-OF-BIRTH	Eligible's Date of Birth
DATE-OF-DEATH	Eligible's Date of Death
DUAL-ELIGIBLE-FLAG	Flag to indicate that eligible was a Medicare beneficiary
FEDERAL-FISCAL-YEAR-QUARTER	Federal Fiscal Year and Quarter to which the Eligibility data apply
MSIS-IDENTIFICATION-NUMBER	A unique identification number used to identify a Medicaid Eligible to MSIS.
RACE-ETHNICITY-CODE	A code indicating the eligible's race/ethnicity
SEX-CODE	Eligible's gender
SOCIAL-SECURITY-NUMBER	Eligible's social security number
TYPE-OF-RECORD	Code indicating whether the eligibility information is for: the current fiscal quarter, corrections, or retroactive eligibility
ZIP-CODE	Zip code of eligible's place of residence

Field Name	Field Contents
Monthly Fields:	
BASIS-OF-ELIGIBILITY	Code indicating the eligible's Basis of Eligibility as of the last day of the month referenced. Codes are: -Not Eligible -Aged -Blind -Disabled -Children -Caretaker Relatives and Pregnant Women -Other Title XIX -Unknown
DAYS-OF-ELIGIBILITY	Number of days an individual was eligible for Medicaid during each month of the report quarter
EPSDT-FLAG	Early Periodic Screening Diagnosis and Treatment program status
MAINTENANCE-ASSISTANCE-STATUS	Eligible's maintenance assistance status classification. Codes are: -Not Eligible -Needy - Receiving Cash -Needy - No Cash -Medically Needy -Other Coverage - prior to 1988 -MCCA Coverage of 1988 and later -Unknown
SS-ELIGIBILITY-GROUP	State-specific eligibility group classification under which the eligible individual is covered
TPL-HEALTH-INSURANCE	A flag indicating whether this enrollee had private health insurance coverage during the month
TPL-HMO-ENROLLMENT	A flag indicating whether an eligible was enrolled in an HMO or prepaid health plan (PHP)

Exhibit B

Medical Claim Data

The Medicaid Statistics Reporting System utilizes three claims files: Inpatient Claims (CLAIM-IP), Long Term Care Claims (CLAIM-LT), and Other Claims (CLAIM-OT). The claim data available, identified by the file type from which it is derived, are:

Field Name	Field Contents
ACCOMMODATION-CHARGES	CLAIM-IP - For institutional claims, the portion of the amount charged that was for "accommodations". Accommodations include room and board at all other levels of inpatient care (regular care, intensive care, newborn care, etc.).
ADMISSION-DATE	CLAIM-IP, CLAIM-LT - The date on which the recipient was admitted to a hospital or long term care facility
AMOUNT-CHARGED	CLAIM-IP, CLAIM-LT, CLAIM-OT - The total charge for this claim as submitted by the provider
ANCILLARY-CHARGES	CLAIM-IP - For institutional claims, the portion of the amount charged that was for service whose cost is not included in an accommodation charge (see ACCOMMODATION CHARGE)
BEGINNING-DATE-OF-SERVICE	CLAIM-IP, CLAIM-LT, CLAIM-OT - For services received during a single encounter with a provider, the date the service was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service began. For capitation premium payments, the date on which the period of coverage related to this payment began.
DATE-CLAIM-RECEIVED	CLAIM-IP, CLAIM-LT, CLAIM-OT - The date the claim was received by the state for processing

Field Name	Field Contents
DATE-OF-PAYMENT-ADJUDICATION	CLAIM-IP, CLAIM-LT, CLAIM-OT - The date on which the payment status of the claim was finally adjudicated by the state
DISCHARGE-STATUS	CLAIM-IP, CLAIM-LT - A code indicating whether the recipient had been discharged as of ENDING-DATE-OF-SERVICE
ENDING-DATE-OF-SERVICE	CLAIM-IP, CLAIM-LT, CLAIM-OT - For services received during a single encounter with a provider, the date the service was received. For services involving multiple encounters on different days, or periods of care extending over two or more days, the date on which the service ended. For capitation premium payments, the date on which the period of coverage related to this payment ends/ended.
INTERMEDIATE-CARE-DAYS	CLAIM-LT - The number of days of intermediate care included in this claim that were paid for, in whole or in part, by Medicaid
LEAVE-DAYS	CLAIM-LT - The number of days, during the period covered by Medicaid, on which the patient did not reside in the long term care facility
MEDICAID-AMOUNT-PAID	CLAIM-IP, CLAIM-LT, CLAIM-OT - The amount paid by Medicaid on this claim or adjustment
MEDICAID-COVERED-INPATIENT-DAYS	CLAIM-IP - The number of inpatient days covered by Medicaid on this claim. Include well newborn days in this field. CLAIM-LT - The number of inpatient psychiatric days covered by Medicaid on this claim

Exhibit B

Field Name	Field Contents
MEDICARE-COINSURANCE-PAYMENT	CLAIM-IP, CLAIM-LT, CLAIM-OT - The amount paid by Medicaid, on this claim, toward the recipient's Medicare coinsurance
MEDICARE-DEDUCTIBLE-PAYMENT	CLAIM-IP, CLAIM-LT, CLAIM-OT - The amount paid by Medicaid, on this claim, toward the recipient's Medicare deductible
MSIS-IDENTIFICATION-NUMBER	CLAIM-IP, CLAIM-LT, CLAIM-OT - A unique identification number used to identify a Medicaid Eligible to MSIS (see section 5.1)
OTHER-THIRD-PARTY-PAYMENT	CLAIM-IP, CLAIM-LT, CLAIM-OT - The total amount paid by all sources other than Medicaid, Medicare, and the recipient's personal funds
PLACE-OF-SERVICE	CLAIM-IP, CLAIM-LT, CLAIM-OT- A code indicating where the service was performed
PRIMARY-DIAGNOSIS-CODE	CLAIM-IP, CLAIM-LT, CLAIM-OT - The ICD-9-CM code for the primary diagnosis for this claim. Primary or principal diagnosis is, depending on the type of claim, the condition established to be chiefly responsible for: - an admission to a hospital or nursing home - consumption of most of the resources used in treatment - a visit to a physician or other practitioner
PRINCIPAL-PROC-CATEGORY	CLAIM-IP - A high level (3 digit) code that identifies the general nature of the principal procedure performed on the recipient

Field Name	Field Contents
PRINCIPAL-PROC-DATE	CLAIM-IP - The date on which the principal procedure was performed
PROVIDER-IDENTIFICATION-NUMBER	CLAIM-IP, CLAIM-LT, CLAIM-OT -A unique identification number assigned to a provider or capitation plan by the State Medicaid agency
QUANTITY-OF-SERVICE	CLAIM-OT - The number of units of service received by the recipient
SECONDARY-DIAGNOSIS-CODE	CLAIM-IP - The ICD-9-CM code for the secondary diagnosis for this claim. A secondary diagnosis is required only for inpatient claims. It is a condition or need for service that coexisted with the primary diagnosis at the time of admission or developed subsequently, and which had an effect on the treatment received or the length of stay.
SKILLED-CARE-DAYS	CLAIM-LT - The number of days of skilled care included in this claim that were paid for, in whole or in part, by Medicaid
SS-DRUG-CODE	CLAIM-OT - A code indicating the drug or medical supply covered by this claim, in National Drug Code (NDC) format
SS-PRINCIPAL-PROC-CODE	CLAIM-IP - A code used by the state to identify the principal procedure performed during the hospital stay referenced by this claim. A principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes. It is closely related to either the principal diagnosis or to complications that arise during other treatments.

Exhibit B

Field Name	Field Contents
SS-PRINCIPAL-PROC-CODE-FLAG	CLAIM-IP - A flag that identifies the coding system used for the SS-PRINCIPAL-PROC-CODE
SS-PRINCIPAL-PROC-CODE-MOD	The state-specific procedure code modifier used with the State-Specific Principal Procedure Code to create the Principal Procedure Category. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.
SS-SECONDARY-PROC-CODE	CLAIM-IP - A code used by the state to identify the secondary procedure performed during the hospital stay referenced by this claim. A secondary procedure is the most significant procedure performed, other than the principal procedure.
SS-SECONDARY-PROC-CODE-FLAG	CLAIM-IP - A flag that identifies the coding system used for the SS-SECONDARY-PROC-CODE
SS-SECONDARY-PROC-CODE-MOD	The state-specific procedure code modifier used with the State-Specific Principal Procedure Code to create the Principal Procedure Category. For example, some states use modifiers to indicate assistance in surgery or anesthesia services.
SS-SERVICE-CODE	CLAIM-OT - The code used by the state to indicate the service provided during the period covered by this claim
SS-SERVICE-CODE-FLAG	CLAIM-OT - A flag that identifies the coding system used for SS-SERVICE-CODE
SS-SERVICE-CODE-MOD	CLAIM-OT - A state-specific service code modifier can is used to enhance the State-Specific Service Code

Field Name	Field Contents
TYPE-OF-CLAIM	CLAIM-IP, CLAIM-LT, CLAIM-OT -A code indicating what kind of payment is covered in this claim
TYPE-OF-COVERAGE	CLAIM-IP, CLAIM-LT, CLAIM-OT - A code indicating whether this is a claim/adjustment for a service covered under standard Medicaid, a premium payment (if CLAIM-OT) or a service covered under a Capitation program
TYPE-OF-SERVICE	CLAIM-IP, CLAIM-LT, CLAIM-OT - A code indicating the type of service being billed. Refer to Section 2700 of the State Medicaid Manual for information on the various types of service.

APPENDIX A: GLOSSARY

Accommodation Charges - The routine hospital room and board charges (including charges for nursing services) for general care, coronary care and/or intensive care facilities.

Ancillary (Departmental) Charges - Those charges, other than routine room and board charges which are incidental to the hospital stay, including: operating room; anesthesia; outpatient services; blood administration; pharmacy; radiology; laboratory; medical, surgical and central supplies; physical therapy; occupational therapy; speech pathology; inhalation therapy; and "other".

Area of Residence - The county and State of the beneficiary based upon the mailing address used for cash benefits or the mailing address used for other purposes, e.g., premium billing. In some cases it may not be the actual area of beneficiary residence, e.g., if the beneficiary has a representative payee.

Assignment - Under Supplementary Medical Insurance (Part B), if the beneficiary and the provider (physician or supplier) both agree, the beneficiary may assign his rights to benefits to the provider. When this assignment method is used, the provider agrees that his total charge for the covered service will be the reasonable charge approved by the carrier. The provider submits a claim to the carrier, and is reimbursed for the reasonable charge, minus the 20 percent coinsurance and any deductible which remains unmet. The provider may then charge the beneficiary only for the coinsurance and any applicable deductible.

Benefit Period (Spell of Illness) - A period of time for measuring use of Hospital Insurance benefits. It begins on the entitled beneficiary's admission to a qualifying hospital or other facility and ends after the 60 consecutive days during which the individual was not an inpatient of any hospital or other facility primarily providing skilled nursing or rehabilitation services. Although there are limits to covered benefits per benefit period, there is no limit to the number of benefit periods a beneficiary can have. The beneficiary must pay the Hospital Insurance deductible for each new benefit period.

Beneficiary Identification Code (BIC) - A one or two position code that identifies the type of social security or railroad board benefits to which the beneficiary is entitled. The Social Security number of the primary beneficiary plus the BIC subscript represents the beneficiary's Health Insurance claim number.

Carrier - A private or public organization with which HCFA enters into agreement to help administer the Part B benefits under Medicare. Also referred to as "contractors," the carriers determine coverage and benefit amounts payable and make payment to physician/suppliers or beneficiaries.

Coinsurance - That portion of covered hospital and medical expenses, after subtraction of any deductible, for which the beneficiary is responsible. Under Hospital Insurance, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through the 90th day of inpatient care, the daily coinsurance amount is equal to one- fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily

coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility care; from the 21st through the 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under Supplemental Medical Insurance, after the annual deductible has been met, Medicare will generally pay 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the beneficiary.

Cross-Reference Number - A Health Insurance Claim Number related to the current number. In cases where an individual becomes entitled under a new number (for example, a woman formerly entitled under her husband's number becomes entitled under her own number), the actions under both are recorded under the current (new) number.

Deductible - The amount payable by the beneficiary for covered services before Medicare makes reimbursement. The Part A deductible is the initial amount in each benefit period which Medicare does not pay. The Part B deductible is the portion of reasonable charges (for covered services each calendar year) for which a beneficiary is responsible. These amounts, currently fixed by law, usually differ from year to year.

Diagnosis Related Groups (DRG's) - Each Diagnosis Related Group represents a broad clinical category based on body system involvement and disease etiology which are similar in use of resources. There are 473 categories. The following guidelines were used: (1) they must have been clinically consistent; (2) they must have had a sufficient number of patients; and (3) they must have covered the complete range of diagnoses represented in the ICD-9-CM, without overlap. They were developed by a Yale University research team and revised by Health Services International, Inc.

Disabled - For purposes of enrollment under Medicare, individuals under age 65 who have been entitled to disability benefits under the Social Security Act or the railroad retirement System for at least two years are considered to be disabled.

End-Stage Renal Disease (ESRD) - For purposes of enrollment under Medicare, individuals who have chronic kidney disease requiring renal dialysis or kidney transplant are considered to have end-stage renal disease. To qualify for Medicare coverage, the individual must be fully or currently insured under social security or the railroad retirement system, or be the dependent of an insured person. Eligibility for Medicare coverage begins with the third month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility; or if a person received a kidney transplant without starting or receiving dialysis.

Entitlement Date - The first day of the month in which an individual is entitled to Hospital Insurance (Part A) and/or Supplementary Medical Insurance (Part B) benefits.

General Enrollment Period (GEP) - An open season period between January 1 and March 31 each year for enrollment of individuals who missed initial enrollment, were terminated,

or cancelled coverage voluntarily. (This procedure applies to Part B and voluntary Part A coverage for uninsured persons).

Group Practice Prepayment (GPPP) - An organization which has a formal arrangement with three or more full-time physicians to provide certain health services to the plan's members who, through the advance payment of premiums ordues, have contributed toward the cost of services.

Health Insurance Claim Number (HIC) - The individual identification number used in the Medicare program to identify each beneficiary. It consists of a Social Security or Railroad account number plus a Beneficiary Identification Code (BIC) that denotes the type of beneficiary for cash payment programs. Most HIC's are 9 digit numbers with letter suffixes and are issued by the Social Security Administration (SSA); those issued by the Railroad Retirement Board (RRB) can be either a 6 or 9 digit number with letter prefixes.

Health Insurance Master Record (HIM) - The HCFA master Medicare file of all individuals in current entitlement status as well as those who have ever been entitled to Hospital Insurance (Part A) and/or Supplemental Medical Insurance (Part B) benefits.

Health Maintenance Organization (HMO) - An organization which provides services to Medicare beneficiaries on a prepaid per capita basis. The HMO will provide both Part A and Part B services and can contract to operate as a "risk-basis" HMO (sharing in any savings it achieves) or a "cost-basis" HMO (with no provision for achieving savings or incurring losses).

Home Health Agency (HHA) - A public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home, such as: physical, occupational, or speech therapy; medical social services and home health aid services.

Hospital Insurance (HI) - HI (also known as Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or railroad retirement systems, for individuals under age 65 who have been entitled for not less than 24 months to benefits under the social security or railroad retirement systems on the basis of disability, and for certain other individuals who are medically determined to have end-stage renal disease and are covered by the social security or railroad retirement systems.

Interim Bill - A bill that does not cover a complete stay in a hospital or skilled nursing facility. It is used when the beneficiary is still receiving services, i.e., has not yet been discharged.

Intermediary - A private or public organization with which HCFA enters into agreement to help administer benefits to institutional providers under the Health Insurance program. The intermediaries determine costs for Part A benefits and make payment to providers.

Lifetime Reserve Days (LRD) - A beneficiary is entitled to 60 hospital lifetime reserve days for inpatient hospital care. At the time regular benefits are exhausted, the patient chooses whether or not to exercise the use of the reserve days. Medicare does not pay for the entire day; the beneficiary pays one half of the inpatient deductible. The beneficiary can use up to a maximum of 60 lifetime reserve days during their lifetime.

Master Beneficiary Record (MBR) - The basic social security master file of all retirement, survivor, disability and health insurance beneficiaries. It is the source file for beneficiaries entitled to Medicare on the Health Insurance Master Record (HIM). HI beneficiary entitlement data, as well as termination, maintenance and premium billing and collection transactions, are processed and exchanged on an on- going basis between HCFA and SSA via the HI system and MBR interface.

Open Item - A record of admission to a hospital or skilled nursing facility for which a related discharge bill has not yet been received.

Outpatient Services - The medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or free-standing dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, X-ray and other radiation therapy.

Periodic Interim Payment (PIP) - A type of payment which furnishes providers with reimbursement for services more quickly than other arrangements. Intermediaries make payment bi-weekly, generally based on a per-inpatient-day rate calculated on estimated cost minus projected deductibles and coinsurance payable by the beneficiary for the services provided.

Premium - A monthly fee paid by Medicare beneficiaries. Part B beneficiaries pay a monthly premium which is updated every July to reflect any changes in program costs. Part A beneficiaries who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums.

Principal Diagnosis - The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Principal Surgical Procedure - The procedure that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or that which was necessary to take care of a complication.

Professional Review Organization (PRO) - The non-profit physician review organization responsible for reviewing the medical necessity, appropriateness, and quality of health care services provided to Medicare beneficiaries by the provider of services. This is essentially the same function performed by Peer Review Organizations (PRO).

Provider of Service - An institution that furnishes Part A and or Part B health services to Medicare beneficiaries. All such institutions must meet the applicable eligibility requirements of Title XVIII of the Social Security Act and regulations issued thereunder.

Hospitals, Skilled Nursing Facilities, Home Health Agencies and Independent Laboratories are examples of providers.

Query - The record sent by the intermediaries and carriers to HCFA Central Office to verify eligibility and coverage. Intermediaries, upon receipt of an initial hospital bill, must determine if the patient is an eligible Medicare beneficiary and if so, the amounts of related deductibles and coverage. This is accomplished by reporting the admission date to HCFA Central Office for screening against the Health Insurance Master file. Information pertaining to entitlement, deductible status and coverage is returned to the appropriate intermediary. Carriers, upon receipt of a bill for medical services rendered, must also determine if the recipient of the services is an eligible Medicare beneficiary, and if so, the status of their
deductibles. The carrier reports the medical services data to HCFA Central Office for screening against the Health Insurance Master file and receives, in return, information pertaining to entitlement and deductible status.

Railroad Retirement Board (RRB) Number - A distinctive number assigned by the RRB to identify the accounts of individuals entitled to benefits under its system. The RRB number may be either a six or a nine digit number, and when used as claim numbers, appears in conjunction with an applicable RRB Beneficiary Identification Code (BIC).

Reasonable Charge - An individual charge determination made by a carrier on a covered Part B medical service or supply. In the absence of unusual medical complications or circumstances it is the lowest of 1) the physician's or supplier's customary charge for that service; 2) the prevailing charge of the physician or supplier rendering the service.

Reasonable Cost - In processing claims for HI benefits, intermediaries use HCFA guidelines to determine the reasonable cost incurred by the individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs which are unnecessary in the efficient delivery of services covered by the health insurance program.

Reimbursement Amount - The amount reported as being paid by the Medicare program to or on behalf of the beneficiary for services provided by the physician or other provider of service including institutions. For institutional providers, this is usually an interim amount which is adjusted at the end of the provider's fiscal year based on its cost report. Beginning October 1983, for most hospitals, this amount will be based on the DRG.

Skilled Nursing Facility (SNF) - A specially qualified institution which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services and which meets specified regulatory certification requirements.

State Buy-In - Term given to the process by which a State may provide Supplementary Medical Insurance (SMI) coverage for its needy, eligible persons through an agreement with the Federal government under which the State pays their premiums.

Supplementary Medical Insurance (SMI) - SMI (also known as Part B) is a voluntary insurance program which provides insurance benefits for physician and other medical services in accordance with provisions of Title XVIII of the Social Security Act for aged and disabled individuals who elect to enroll under such program.

Value Code - A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization.

Code Structure

Professional Component included in charges and also billed separately to Carrier	For use on Medicare and Medicaid bills if the State requests this information.
Medicare Blood Deductible	Total cash blood deductible.
Medicare Cash Deductible	Medicare cash deductible.
Medicare Lifetime Reserve Amount in the First Calendar Year.	Medicare lifetime reserve amount charged the year of admission.
Medicare Coinsurance Amount in the First Calendar Year.	Medicare coinsurance amount charged in the year of admission.
Medicare Lifetime Reserve Amount in the Second Calendar Year.	Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
Medicare Coinsurance Amount in the Second Calendar Year.	Medical coinsurance amount charged in year of discharge where the bill spans two calendar years.
Working Aged Beneficiary/ Spouse with Employee Health Plan (EGHP)	Amount shown is that portion of a payment from a higher Spouse with Employee Group EGHP insurance made on behalf of an beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
ESRD Benficiary in the 12 Month Coordination Period with EGHP	Amount shown is that portion of a payment from a higher priority EGHP insurance made on EGHP behalf of an ESRD beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the

	provider claimed conditional Medicare payment.
Automobile, No Fault or any Liability Insurance	Amount shown is that portion of a payment from a higher priority automobile, no fault or liability insurance made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
Workmen's Compensation (WC) Including Black Lung	Amount shown is that portion of a payment from a higher priority WC insurance made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
VA, PHS, or other Government Program	Amount shown is that portion of a payment from a higher priority VA, PHS, or other Federal Agency made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of day or cost outlier payment to be made.
Patient Liability Amount	The amount shown is that which you or the PRO approved to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
Amount Approved by PRO to be Paid Under Waiver	The amount shown has been determined by the PRO to be payable under waiver although all, or part of, the services on this bill have been denied.

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